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The Practice of Physiotherapy: Theoretical and Contextual Reflections.

Penelope Anne Roberts

A thesis submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Philosophy

School of Health and Social Care,
Sheffield Hallam University

October 2000

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Dedication

This thesis is dedicated to Peter, Joanna and Andrew and all those of an enquiring mind who struggle to make sense of their reality.

Acknowledgements

The Department of Health and Social Security awarded me a Research Tranining Fellowship which funded the first two years of this work and enabled me to carry out the fieldwork. I would like to acknowledge this support without which this work would not have been started. However, this thesis would never have been written without the support of a great many people. Dr Pat Lyne provided guidance in the early stages and helped me towards an understanding of the research process; Professor Gerry Larkin has been an erudite and challenging supervisor who has always seemed to understand where I wanted to go; Thelma Turner and North Derbyshire Health Authority encouraged and supported me with study leave and financial help; many colleagues in practice, education and on CSP Council allowed me to bend their ears and grapple with some difficult issues; many others pointed me in useful directions; Dr Diana Daltrey has encouraged me and granted me study leave to complete this work; I owe a lot to all these people, but above all of them one person stands out. I would like to acknowledge the tireless support of Professor Anne Parry, without whom this thesis would never have been started, or completed. She never gave up on me and walked the extra mile whenever I was flagging. Whether this work is worthy of all that has been put into it is not for me to judge. It is mine, mistakes and all, and all I can say is thank you Anne for being there.

Pennie Roberts

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Abstract

This thesis is an examination of the practice of physiotherapy, an exploration of the context within which the profession of physiotherapy developed and an identification of the theoretical frameworks within which it is practised. The experiences of physiotherapists and nurses working in particular settings at a specific point in the development of the profession provided a starting point for the study. Physiotherapy, a profession openly dependent for a significant part of its history on medicine for its practice and knowledge base, is contextualised with reference to the development of a medical hegemony, the changing role of women in society, and the development of specialisms within physiotherapy.

A methodological framework was developed through the use of a naturalistic design which places the researcher within the study and legitimises personal perspectives. Knowledge of the field prior to the study, fieldwork observations, and findings from two sets of interviews generated the data which provided the framework for an exploration of the theoretical base for the practice of physiotherapy.

The thesis concludes by examining the components of context and theory which are fundamental to the practice of theory, and places them within a new framework. This new framework or paradigm is based on a re-evaluation of the concept of holism and goes back to the origins of this model which developed amidst the chaos of post-Boer was South Africa. The meaning of holism has been changed to make it nearer the concept of summative dualism which fits well with key concepts of balance, harmony and homeostasis. True holism is about movement and change and this is proposed as an appropriate model on which to base a paradigm for physiotherapy.

1. INTRODUCTION

Physiotherapy is a profession which has developed under the influence of a range of factors and which continues to respond to external and internal drivers. Both the context of practice and the content of physiotherapy are continually changing and the debate about whether there is a recognisable set of skills that can be labelled physiotherapy, or whether physiotherapy is what physiotherapists do, is one which has gone on ever since there were practitioners of the art and science of physiotherapy. Parry (1995) averred that she could not identify a profession that had a "less certain grip on its own identity". More recently the debate about what physiotherapy is has moved from the examination of a set of skills or techniques to an attempt to identify a body of knowledge unique to the practitioners of those techniques and separate from other disciplines such as medicine. (Parry 1991; Richardson 1993; Roberts 1994). The importance of identifying this body of knowledge has been stressed by many, including Higgs and Titchen (1995).

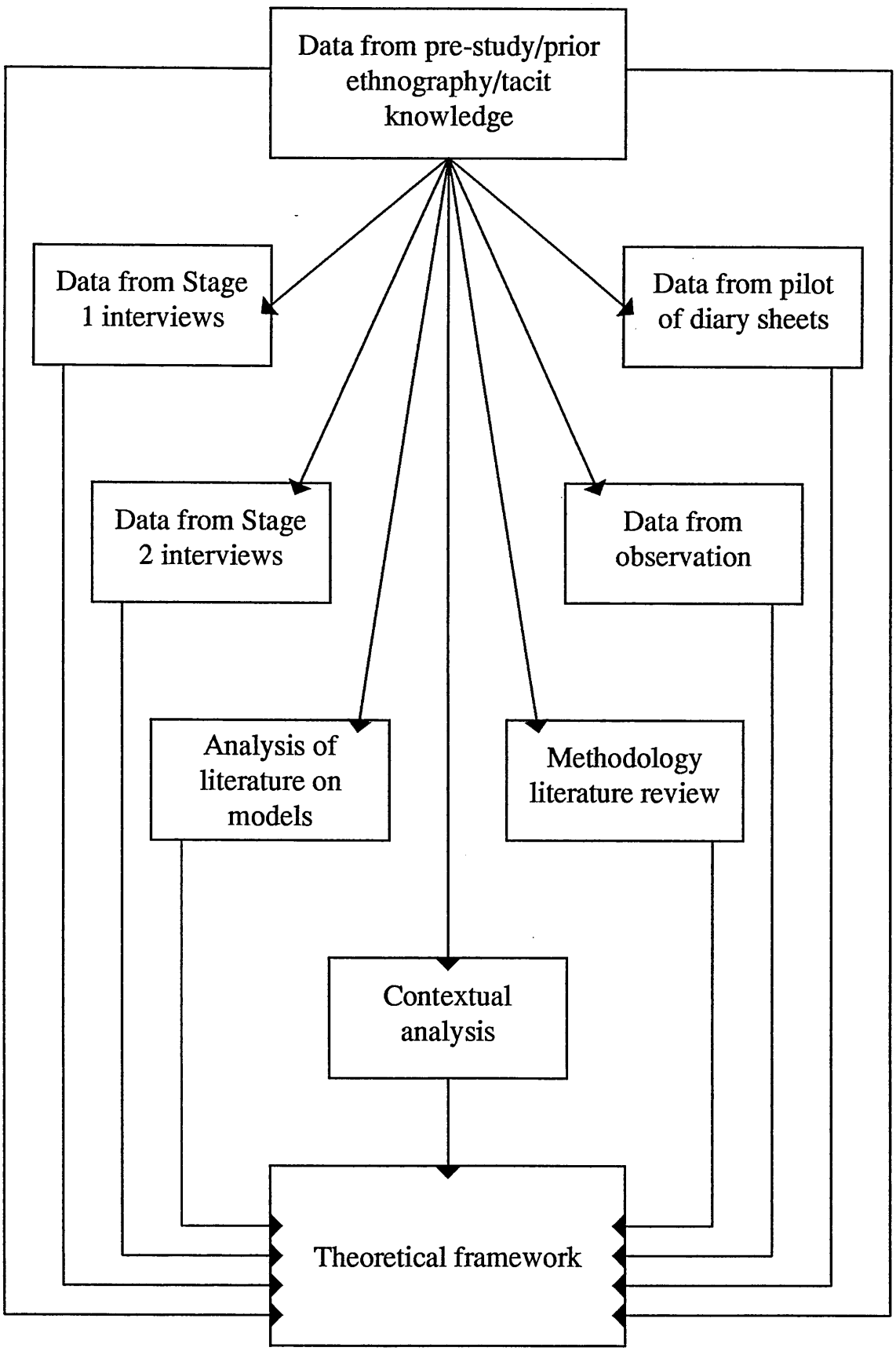
The profession of physiotherapy has many roots and branches. Some of its roots, such as massage and exercise, can be traced back to the baths and gymnasia of ancient Greece and Rome, and China 3000 years BC (Barclay 1994); some of its branches are taking physiotherapy into new areas such as the physical and psychological assessment of exposure to different occupations (Frontline 1997). The history of the profession is that of an eclectic movement, deriving its practices from a range of sources and with no attachment to a particular set of philosophies or beliefs. It is essentially a pragmatic profession - "dealing with matters with regard to their practical requirements or consequences." (Concise Oxford Dictionary 1990).

This thesis is an exploration of the practice of physiotherapy, its attempts to establish a theoretical base, and the effect of the contextual issues which frame it. It is an exploration of a profession which moved away from independent, community based

Figure 1
How and where the three strands of the thesis are presented

THEME	HOW EXPLORED	WHERE PRESENTED
Context	Exploration of relevant historical, social and political influences on the development and practice of physiotherapy.	Background (Chapter 2)
Practice	Examination and analysis of physiotherapy practice in two specific settings through the eyes of: *physiotherapists (the insider's view) *nurses (the outsider's view).	Fieldwork Findings (Chapter (4)
Theory	Identification, analysis and discussion of theoretical models available to and used by physiotherapists as a basis for practice.	Models (Chapter 5)

How the data from different sources were used to develop the theoretical framework



practice, chose to operate under the patronage of medical men within hospitals and is now emerging as an independent, or quasi-independent profession, working in a variety of settings in response to changing social and political demands.

There are three main strands to the thesis. One is an exploration of the social, historical and political contextual issues which have influenced the way in which physiotherapy has been practised over the last decade, the second an examination of the clinical practice of physiotherapy in two specific settings, and the third the identification of theories used by physiotherapists to explain their practice. (Figure 1)

Fieldwork carried out over several months in 1987 provided a picture of the clinical practice of a group of physiotherapists at a particular time and in particular places. From the extremely rich and varied data generated by the fieldwork, a framework for the exploration of the theoretical and contextual issues that surround the practice of physiotherapy was built. The data from that fieldwork is presented as the foundation for the development of the theoretical framework of the thesis. The themes that emerged from that period of the study informed the development of the theoretical framework and are reflected throughout the analysis of a range of issues, theoretical and contextual, pertinent to the practice of physiotherapy. (Figure 2).

The search for explanations and for patterns in the development and delivery of physiotherapy practice led to the discovery of a range of theories available to and used by physiotherapists. An exploration of the origins and implications of these theories, and their underlying beliefs and assumptions, illuminated the search for paradigms of physiotherapy, an urgent need for the profession identified by Richardson (1993), Grant (1995) and others. The hegemony of medicine and its overwhelming influence on the theoretical framework within which physiotherapy operates, alternative models of health, and in particular the social and holistic models, form a substantial part of the search for identifiable theory on which the practice of physiotherapy is based.

The historical, social and political context in which physiotherapy, and indeed all health care, is delivered is examined, with the key features being the emergence of an organised female profession able to articulate its history, women's role in society and in particular in the world of medicine, the organisation of health care delivery - the development of hospital based medicine, the NHS reforms of the 1990s, and more parochially the issue of the regulation of the physiotherapy profession through state registration in 1960 and beyond.

The government reforms of the 1990s in particular had a massive impact on the way physiotherapy is delivered. The shift of resources and control to doctors in primary care, the decision to provide more services, particularly for elderly people, in community settings rather than in hospitals, and the split of health care provision into purchaser and provider components, are manifestations of the revolution that has swept across health during this decade. Physiotherapy has not been exempt from its effects, and the changing context is examined in the light of its impact on the practice of physiotherapy.

The story of the changing nature of physiotherapy education, and in particular the impact of the move into institutions of higher education, is told as an example of the influence of context on the development of a profession, control over the process and content of education being an important part of professional identity. The evolution of specialisms is explored to illustrate the influence of theory on the unfolding practice of physiotherapists and the tensions created by an inadequate theoretical base.

The strength of this thesis lies in its multiple levels of exploration - both methodologically and contextually. Methodologically the design emerged from within the thesis and was generated concurrently with the analysis of the findings. Qualitative research data gleaned from the fieldwork, from contemporary and historical accounts of the development of profession and its relationship with other

professions, notably medicine and nursing, and from analysis of models of health care, created the context for an examination of physiotherapy practice. (Figure 2).

1.1 The Practice of Physiotherapy

The research process began with an examination of the clinical practice of physiotherapy within particular settings and it was from the data produced during the fieldwork that the thesis developed. The impetus for it came from a desire to explore issues arising from work done with elderly patients in two health authorities and this provided the setting for an examination of the practice of physiotherapy. During the time spent working as a clinical physiotherapist in these two hospitals the varying nature of the relationships between physiotherapists and nurses and an apparent effect of this relationship on patient care was noted. Specifically it was observed that physiotherapists working on wards for the elderly relied heavily on nursing staff both qualified and unqualified, for referrals.

Consultant medical staff at both hospitals gave 'blanket referral', that is they considered the physiotherapy staff to be clinically and managerially responsible for deciding who needed physiotherapy treatment. While most physiotherapists welcomed this recognition of their professional autonomy, it meant in practice that no screening was done by the medical staff and therefore the workload of assessing every patient for possible physiotherapy intervention was unmanageable. In neither hospital was it considered possible or even desirable to assess all patients regularly to see if either new admissions needed physiotherapy or if existing or long-stay patients had deteriorated and would benefit from physiotherapy intervention. It was therefore essential to make use of the knowledge that other staff, and in particular nurses, had about the patients to help prioritise treatment and make more effective use of the physiotherapy input available.

A close working relationship with nursing colleagues was considered necessary by the physiotherapists to facilitate their therapeutic input. However, marked differences were noted in the way nursing staff reacted to physiotherapists. Many were openly hostile and appeared to resent the involvement of both physiotherapists and occupational therapists in patient care. Others welcomed additional professional expertise and did not appear to feel threatened by other practitioners wanting to work closely with them. It was felt at this stage that nurses at the two different hospitals held markedly different attitudes towards cooperating in a multi-disciplinary delivery of care and that this was largely dependent on where they worked. Several reasons for these different attitudes were considered at this stage.

There were different experiences of physiotherapy in each hospital; one had a long history of a well established physiotherapy service, the other did not. There were different working environments; in one hospital there was a small physiotherapy department attached to the geriatric wards which meant that patients received some of their physiotherapy off the ward and out of the nurses' charge, in the other hospital there was no physiotherapy department and all treatment was done on the ward. There were different management strategies; physiotherapy management in one hospital was dynamic and the superintendent physiotherapist was determined to give the service a high profile and make it as effective as possible. In the other the service was part-time and managed from the acute hospital two miles away by a superintendent physiotherapist who rarely visited the site. Nurse managers in one hospital appeared willing to work with physiotherapists to benefit the service to the patients; in the other it appeared that nurse managers were determined to prove they could manage without any paramedical input and that any friction was due to personality clashes with individual therapists. These issues and their effect on the delivery of care to elderly people was the starting point for the fieldwork.

The specific professional interest of the researcher as a physiotherapist was the care of

elderly people. There were two particular clinical areas of interest - continence promotion and the management of pressure sores. Incontinence and pressure sores were major problems for elderly patients and all those concerned in their care. These two clinical areas became a focus for questions relating to issues of physiotherapist-nurse interaction.

Although at this stage the emphasis of the study was intended to be on nurses' perceptions of physiotherapy it was thought that a preliminary stage would be to discover what physiotherapists themselves thought physiotherapy had to offer elderly patients. The thinking behind this was that it would be useful to document how physiotherapists described their practice as a precursor to documenting how others described it. It was this decision to move from an exploration of what nurses thought physiotherapists did to an examination of what physiotherapists thought they did that laid the foundation of the thesis.

The emphasis of the study at this stage was very much on care and how the professional relationships between professionals working with the elderly affected the care received by patients. Various quality assurance measures, developed particularly for nursing, were examined to see if inter-disciplinary cooperation was a factor taken into account. While various professional groups were each evaluating the service they delivered, it did not appear that anyone was taking an overall view of the total care received by patients. Early objectives therefore included such phrases as "to describe aspects of quality of care offered to elderly patients..." and "to investigate relationships between inter-disciplinary management of elderly patients and quality of care delivered."

However, as the study developed it became apparent that this was too large and complex an area to be investigated satisfactorily within the research project as it stood. The original aims were therefore modified to concentrate specifically on physiotherapy

practice and the understanding of it held by physiotherapists and nurses. In order to make meaning of physiotherapy as a practical application of skills an understanding had to be gained of the mind set of the practitioners themselves.

> "Human behaviour cannot be understood without reference to the meanings and purposes attached by human actors to their activities." (Guba and Lincoln 1994 p106).

Results from the analysis of the fieldwork data showed that relationships between nurses and physiotherapists were poor in both settings. The usual explanation given was that there were 'difficult' personalities and that this was the basis of disagreements. However, it appeared to be more deep rooted than that and analysis of the data showed that physiotherapists and nurses were using different conceptual models to determine their practice. Differences in these models within the same setting was leading to conflict in practice with a lack of understanding of the origins of the conflict. The conceptual models used were not profession specific but appeared to be determined by contextual issues. The next stage was therefore to examine the origins of these models, particularly those relating directly to physiotherapy, and their effect on practice and on relationships with others. From the specifics therefore of the practice of physiotherapy in a particular setting, the research expanded to encompass the meanings given to the profession by its practitioners, their conceptual frameworks and the theoretical basis of physiotherapy.

1.2 Practitioner Research

In looking for a methodological approach to examine the issues described above the importance of using the involvement of the researcher as a strength rather than something to be explained away became apparent. Punch (1994) argues that personal and anecdotal accounts, often not recorded, add up to a "stream of thought" that attacks traditional methodology and relies on total immersion in the field. Listening to the stories told by individuals about their knowledge and understanding of what they do

challenges claims that research, like science, is intrinsically neutral. An approach was adopted therefore that recognised the importance of the stories people told, and allowed the design to emerge during the process of the research.

One of the strengths of qualitative data is that it provides contextual information and overcomes the problems of the context stripping of the positivist approach. Research methods which are designed to exclude variables which, if included, might alter the findings are limited in their usefulness as the findings from them are only applicable to similarly contextually stripped situations. (Guba and Lincoln 1994). The advantages of close links therefore were felt to outweigh any potential and actual disadvantages.

Access was readily granted to the researcher and it seemed that an insider studying aspects of health care was not as threatening as an outsider. This clear identity as a physiotherapist also facilitated access to the previously employing health authority. It was seen as good for a physiotherapist to be studying aspects of care of elderly people at a time when the profession was realising the importance of improving its research base. Many of the professionals with whom negotiations were undertaken identified closely with the questions being asked in the study and all appeared to be of the opinion that these were important issues that should be made explicit.

Practitioner researchers bring to a study a whole wealth of background knowledge and experience that can only be acquired by working as that particular professional in that specific area. A long period of what is essentially participant observation and total immersion in the culture in which the investigation is to be grounded means that professional terminology is known and common working practices and routines understood. (Vidich and Lyman 1994). The practitioner is therefore in a good position to record what is different and what is usual in their own field of expertise. This can be a clear advantage over the stranger to whom everything may appear unusual. It enables focus on unusual practices, or events which in their experience are

not the norm. Having good knowledge and experience in the field enables the intuition of a practitioner to identify and prioritise issues and to select areas to be investigated. These are more likely to be considered important or relevant by other practitioners and to be of direct relevance to clinical practice.

As the study was so deeply rooted in practice it was seen as unnecessary and indeed impossible for the researcher to adopt a new role for the period of the investigation. As long as it was acknowledged that this was a piece of research into clinical physiotherapy by a physiotherapist then the potential disadvantages of observer bias could be used to enhance the investigation.

Practitioner research, particularly involving participant observation, has its own inherent problems, ethical and practical, and is not a soft option. These were addressed throughout the study, particularly the fieldwork stage, and resolved with careful thought and consultation with participants. That they affected the fieldwork and its findings is undeniable. However, the value of an emergent design is that the lessons learnt from the process itself feed into the design and are part of the total picture instead of being something that distorts or warps the original methodology. Denzin and Lincoln (1994) describe the process of designing a qualitative research project as beginning with a socially situated researcher who moves from a research question to a paradigm or perspective and then into the empirical world. This is the model that best describes the approach adopted in this thesis.

1.3 The building blocks of the thesis

Analysis of the data collected during the fieldwork identified a profession which was unsure of, or unable to explain, its theoretical base. Physiotherapists described their practice in terms of the application of practical skills or techniques rather than as the application of knowledge or theory. Nursing staff on the other hand appeared to have

a clearer idea of what they termed 'models' of practice. Published literature on these nursing models was available and did not appear to be matched by anything in the physiotherapy literature. However, an examination of the roots of these nursing models identified underlying conceptual frameworks which illuminated health care in general and allowed physiotherapy paradigms to be explored. A significant part of the thesis therefore is the identification and examination of a range of models which impact on or explain the practice of physiotherapy. In particular, the tension between models which explain physiotherapy in mechanistic terms, viewing the human body as a machine subject to purely physical laws, and those which seek to explain human existence in metaphysical terms, is identified and examined.

Contextual issues which were identified as being important and relevant to the development of physiotherapy as a profession were examined and included in the thesis to provide a clear framework within which the practice of physiotherapy is placed. These include the role of women in society at a key point in the development of the hegemony of medicine, the origins of organised healthcare and its regulation. These strands of the thesis are clearly large enough to warrant theses in their own rights and are included here only in so far as they illuminate the practice of physiotherapy, not as independent studies.

The study progresses from the specifics of physiotherapy practice as identified in the fieldwork, through the examination of societal and political influences on the development of the profession, into an exploration of the theory underpinning that practice. This showed a rapidly developing research base and a growing awareness of the importance of establishing sound theory to underpin physiotherapy practice. (Parry 1991, Richardson 1993, Roberts 1994, Parry 1995).

However, tensions within the profession became evident with the emphasis on establishing credibility with others, notable medical practitioners, by defining

physiotherapy in their terms. Difficulties with this approach led to a search for explanations that were more firmly founded in the practice of physiotherapy. The drive to establish a credible body of knowledge has come from several sources - political with the call for evidence based practice and cost effectiveness, financial with competition between practitioners including the advent of state registration for osteopaths and chiropractors, and academic with the move of physiotherapy undergraduate education into institutions of higher education. The thesis therefore addresses these issues in so far as they have influenced the development of physiotherapy theory and affected the practice of physiotherapy.

The thesis deals with issues that are complex and interrelated. They are of necessity dealt with discretely but drawn together in the conclusion which identifies the components of a new paradigm for physiotherapy. These components are those which the work undertaken has identified as being the key drivers for physiotherapy practice in the 21st century. They are focused around two key themes - new relationships between physiotherapists, patients and other health care professionals, and the acknowledgment and articulation of a range of theoretical models which currently underpin practice. Key to a new paradigm is holism, the exploration of which leads to the conclusion that this model for change could form a firm basis for the future of physiotherapy.

At a time when the health care professions face new challenges, new ways of thinking about practice are required. This challenge to rethink what physiotherapists do and why, and their relationship with other health professionals may well lead to a re-structuring of professional boundaries. (Roberts and Smith 2000; Roberts, Smith and Balmer 2000; Smith, Roberts and Balmer 2000). This thesis offers a framework for exploring the origins of the profession of physiotherapy, the theoretical and contextual framework for its practice, and draws on these frameworks to identify the elements of a new paradigm for physiotherapy.

1.4 Objectives

1. To investigate physiotherapy practice and the understanding of it held by physiotherapists and nurses in particular settings.

2. To investigate the theoretical models available to and used by physiotherapists.

3. To investigate the contextual issues which have influenced the development and practice of physiotherapy.

4. To develop a methodology appropriate to the emerging study.

5. To identify the components of a new paradigm for physiotherapy.

2. BACKGROUND

An investigation of issues of contemporary physiotherapy practice necessarily involves a study of the accounts of the history of the development of physiotherapy. This section describes that development, within the United Kingdom, and varying accounts of the origin of the profession. Physiotherapy's relationship with medicine is also examined in the light of the events leading up to the formation of the Chartered Society of Physiotherapy. The story of the push for specialisation within the profession and the development of clinical interest groups is then recounted to gain insight into some of the issues which have shaped the professional practice of physiotherapy.

2.1 The Organisation of Physiotherapy

The Chartered Society of Physiotherapy (CSP) is the professional association of Chartered Physiotherapists in Britain. The term professional association is used to describe the formal organisation of the practitioners of a profession (Carr-Saunders and Wilson 1933 cited Sim 1985). According to these authors the functions of a professional society are various and include controlling standards of entry to the profession through an examining and licensing system. Its existence therefore fulfilled one of what Sim (1985) claims to be the true criteria of a profession, that of selective entry. However the passing of the Professions Supplementary to Medicine Act (1960) significantly affected the control the CSP could exert.

The debate on state registration had started in the 1920s when Barclay (1994) notes that the threat to private practitioners from untrained rivals led to calls for legislation similar to that controlling dentistry. The debate was to continue until the passing of the PSM Act in 1960 but as this only controlled those physiotherapists working in the National Health Service the needs of private practitioners was not addressed until the review of the PSM Act undertaken on behalf of the government by JM Consulting Ltd

in 1996 addressed the issue of protection of common title.

Up to the formation of the Council for Professions Supplementary to Medicine (CPSM) in 1960 the CSP controlled its own educational process; the setting up of the CPSM threatened this (Jones 1991). While retaining ultimate control the CPSM delegated its examining and licensing powers to a Joint Validating Panel made up of CSP and CPSM members. Jones (1991) however argues that through the CPSM, the setting up of which was welcomed by physiotherapists and other professionals involved, ultimate control of the physiotherapy curriculum by physiotherapists was lost. The Physiotherapy Board of the CPSM has nine physiotherapy members and eight non-physiotherapy members, but all decisions have to be ratified by the Council, where there is no physiotherapy majority, then by Privy Council.

In evidence to the Cope report (DHSS 1951) the Chartered Society of Physiotherapy had called for a 'Council for Physical Therapy' similar in concept to the General Nursing Council (Larkin 1983, Barclay 1994). This call was rejected and it is noted by Barclay (1994) that Captain Nathan, a private practitioner member, reproached Council for its ineffectual dealings with the Ministry of Health. He claimed that Ministry officials:

> "regarded the CSP not as an important body with whom they were glad to confer, but as an irritating body who were always insinuating their imagined status in support of their arguments, and because of this ....were taking little heed of their submissions."
> (Barclay 1994 p164)

The Cope proposals were opposed by all those affected by it and their reactionary nature had the effect of uniting a disparate group of medical auxiliaries. They were eventually modified into what was to become the PSM Act (1960) which was a compromise. It gave physiotherapy the status of a profession supplementary to

medicine, more than the British Medical Association wanted, but less than physiotherapists had hoped for.

Growing dissatisfaction with the workings of the 1960 Act was targeted on two areas. One was the ineffectiveness of the legislation in dealing with unqualified practitioners in the private sector, anxieties exacerbated by the refusal of the government to prohibit the use of unregistered physiotherapists by fundholding General Practitioners. In 1981 a DHSS (1981) consultative document had been published which seemed to offer the opportunity to gain protection for the title physiotherapist. However the profession could not agree on whether it should go for closure of title or closure of function. (Barclay 1994). The other main complaint was that the disciplinary procedures of the CPSM were not adequate or appropriate to deal with an increasingly litiginous population.

The refusal of the government to consider new legislation was undermined by a Bill proposing the setting up of the General Council and Register of Osteopaths in 1993, a move which led to renewed calls for an urgent revision of the Act that governed the practice of physiotherapy. As noted by Simon (1993) the CSP's attitude was generally welcoming to a statutory register for osteopaths but it was, he claimed, saddened that the Government was not prepared to give the same level of protection of title to physiotherapists.

> "We will continue to press for revision of the 1960 Professions Supplementary to Medicine Act to bring registration arrangements for PSMs into line with other health care professions. The Osteopaths' Bill strengthens our case." (Simon 1993 p6)

Faced with the prospect of nine separate professions calling for their own Act Baroness Cumberledge recommended a review be carried out. In 1996 JM Consulting Ltd published their report (JM Consulting Ltd 1996).

The decision of a previously intransigent government firmly in favour of deregulation to commission a review should not be seen only as a reaction to the growing demands for revision by the professions concerned, in particular physiotherapy and chiropody. It was also an opportunity for the government's own agenda for the professions allied to medicine to be effected. In return for protection of common title the professions were losing their autonomous Boards and being put under the control of an overarching Council which would have no single professional voice. Physiotherapy was being put together with professions as diverse as art and drama therapy, radiography and bio-medical science. The existence of separate Councils for medicine, dentistry, nursing and osteopathy, professions with which physiotherapy at times had more in common than those covered by the PSM Act, was an anomaly that was of little concern to anyone outside the professions involved. A typical comment voiced at a meeting to discuss the issues around the review, and made by a key medical stakeholder, was that the nine professions had common roots as they all practised primarily in hospitals and under the control of doctors.

2.2 The Origins of the Professional Body

In 1948 the CSP published its official history (Wicksteed 1948). This commissioned work set out to trace the origins of organised physiotherapy in this country. According to this account the roots of modern physiotherapy are to be found in nursing. Wicksteed starts her account of the history of the present Chartered Society of Physiotherapy in the summer of 1894 when nine nursing and midwifery colleagues joined together to form the first Society of Massage. The CSP acknowledges these nine nurses as its founders and chronicles the Society of Trained Masseuses as the forerunner of the present Society (CSP 1980).

This view is accepted by nurses who have investigated the relationship between nursing and physiotherapy. As Pearson and Vaughan (1986) explain:

> "An understanding of the origins of many of the complementary paramedical groups such as physiotherapists ... clearly demonstrates that their roots lie in nursing." (Pearson and Vaughan 1986 p21).

Wicksteed traced the development of the CSP through to 1948 and the arrival of the National Health Service. Milestones along this path include amalgamations with other societies such as the Institute of Massage and Medical Gymnastics (1920), and The Incorporation of Physiotherapists (1945). In May 1980 the CSP published details of the stages the Society had gone through after 1948. These include amalgamations with The Faculty of Physiotherapists in 1968 and The Physiotherapists Association Ltd in 1970. Since this account was published there has been another amalgamation - with the Society of Remedial Gymnastics in 1986. This latest merger brought back into the fold of the CSP a splinter group of male gymnasts who set up the Society of Remedial Gymnasts after the second world war (Mercer 1979).

Little has been written about the origins of many of these groups, Barclay's history of the Chartered Society of Physiotherapy 1894-1994 (1994) being the seminal work in this area. However it is clear, from their titles and from Barclay's descriptions, that they were not as firmly embedded in the hospital nursing tradition as the nine women who formed the Society of Massage in 1894. It may be that the choice of the official archivists of the organisation to follow the strand connecting the Chartered Society of Physiotherapy to these nine women rather than alternative options was made to reinforce the respectability of the origins of physiotherapy.

The existence of various organised groups of physiotherapists, and the work being done in Sweden by such people as Madame Bergman Osterberg, Gerda Nyholm and Miss Adolphson, whose contribution to the development of the profession is acknowledged by Wicksteed, demonstrates that the history of organised physiotherapy practice is not synonymous with the history of the Chartered Society of Physiotherapy.

Equally in claiming through its Royal Charter to be the legitimate practitioners of massage the Chartered Society is assuming a role that may not go unchallenged. As Larkin (1983) states:

> "Physical medicine itself, particularly in the form of massage and manipulation has very ancient origins." (Larkin 1983 p92)

Pratt and Mason (1981) also emphasise the point that massage is one of the most ancient therapies known to mankind. Indeed, towards the end of 1992 a British Council of Massage has been set up to bring together all those practising massage in order to regularise its practice. Chartered Physiotherapists may claim to be the rightful practitioners of this therapy but massage exists outside the auspices of the CSP. However, the sequence of successful mergers that have occurred during the CSPs existence have left it in the position of being the representative organisation for all practitioners of physiotherapy in the UK apart from a small number, estimated in a 1994 CSP exercise as 300, of unregistered physiotherapists, most of whom are trained by and members of the SMAE Institute (Simon 1994 personal communication).

What is clear is that once masseuses and teachers of remedial exercises formed themselves into discrete organisations it was possible for a history of the profession to be chronicled. Once chronicled this account became the accepted version and thus the history of physiotherapy in this country has been taken to mean the history of the Chartered Society of Physiotherapy. The appropriateness of this history has been challenged by Williams (1986):

> "Our founders did not begin physiotherapy, indeed far from it. Massage is a very ancient form of treatment." (Williams 1986 p69)

Nursing historians, amongst others, have challenged the authorised versions of their origins. Davies (1980), Versluyen (1980), Ehrenreich and English (1973) have all offered evidence to counter the traditional picture of the modern nurse created by

Florence Nightingale's reforming zeal out of Dicken's Sarah Gamp. They have chosen to examine the role women played as lay healers throughout history which has been largely ignored by those who chronicled nursing history. This approach has implications for physiotherapy which needs to look further back than 1894 for its origins. As Versluyen (1980) states:

> "To date the history of health care has been fairly narrowly conceived as the history of organised medicine." (Versluyen 1980 p177)

The accepted account of physiotherapy as having originated from within nursing has led to claims by nurses that physiotherapy skills were once nursing skills which nurses somehow lost. Pearson and Vaughan (1986) see this as a natural result of the reductionist approach which they claim so strongly influenced medicine and nursing and led to the formation of new occupational groups which took over some of the functions previously carried out by nurses. They particularly cite the loss of the skill of 'encouraging mobility' to physiotherapists as evidence of the inappropriateness of a reductionist approach to health care. However as noted by Davies (1980) histories of professions are often written from within that profession and with a special professional purpose.

Whatever the motives or purposes of the chroniclers of physiotherapy history, or however inappropriate it may in the future be considered, physiotherapy is currently seen by many nurses and physiotherapists as a branch of nursing which split away in 1894, rather than as a separate profession.

2.3 Physiotherapy and its Relationship to Medicine

In 1894, when the first Society of Massage was formed, massage had been enjoying a revival of its popularity in the high society of that time. Sir William Bennett (quoted in Wicksteed 1948) noted that:

> "it became at one time almost a matter of honour for any lady of position in society to have a course in massage, and to be visited by her masseur or masseuse, generally once in the day before she commenced her other occupations." (Wicksteed 1948 p22).

This growth in the popularity of massage was accompanied by a number of scandals concerning 'houses of ill-fame' and a linking in the public mind of massage with these less than reputable establishments. A series of 'Massage Scandals' filled the popular press in 1894 but what was very alarming to those ladies who were anxious to establish massage as a respectable form of treatment was the publication in July 1894 of an article in the British Medical Journal (1894). Cited in Wicksteed this article states that its author found it necessary to warn readers against the use of massage on account of the number of unscrupulous person practising it. Wicksteed claims that the women who formed the 'Society of Massage' in 1894 were motivated by a concern that massage should become respectable and that it was the threat to the 'good name' of massage that led to the formation of The Society of Trained Masseuses in 1895. As Barclay (1994) notes:

> "...the founder's action was... a reactionary protection of their reputation amid the 'massage scandals' of the 1890s..." (Barclay 1994 p xii)

Twenty five years later The Hospital carried a report of efforts being made by London County Council to regulate massage establishments. The Select Committee of the House of Commons had been informed by the Council that existing legislation was inadequate and not nearly strong enough to suppress what was considered 'a grave social evil.' (The Hospital 1920). The report notes that:

> "It is only just to the properly conducted massage establishments that the less reputable places should be ruthlessly weeded out." (The Hospital 1920 p179).

It is noted with some satisfaction in The Hospital (1920) that The Chartered Society of Massage and Medical Gymnastics - formed in that year from the Incorporated Society of Trained Masseuses with the Institute of Massage and Remedial Gymnastics and granted a Royal Charter - had been 'exceedingly fortunate' in securing as Chairman of Council Sir. E. Cooper Perry, consulting physician to Guy's Hospital and Principal Officer to London University. From 1920 until 1972 the post of Chairman was held by a succession of medical men and women and it was not until 1972 that the Chartered Society of Physiotherapy, as it had become in 1943, was to elect a physiotherapist as Chairman of Council - Miss Lois Dyer (Barclay 1994).

Opting for medical patronage appears to have been the means by which these women believed they could obtain the respectability they deserved. From the very first attempts to achieve legitimacy it was made clear that masseuses were to treat patients only under instructions from a qualified doctor. This medical control was reinforced throughout the development of the professional organisation of physiotherapy in this country. The founders of the CSP wanted the medical profession to give them the credibility and respectability they felt they needed and in return accepted a reduction in their professional autonomy.

Barclay (1994) considers the mid-1970's to be the point that marked the demise of medical control and the acquisition of full professional status for physiotherapy. It was at this time that the bye-laws were changed, with the necessary agreement of the Privy Council, to allow treatment by physiotherapists *in emergencies* without a medical referral, but the norm was still that a medical referral was required. However, control of the profession through the need for medical referral except in emergencies was to continue until January 1987 when, under the new bye-laws introduced in that year, Chartered Physiotherapists were permitted to take direct referrals, but with the understanding that close cooperation would be maintained with the medical profession.

This decision to achieve respectability by opting for medical patronage had far-reaching effects on the way physiotherapy practice developed. The issue was not just one of physiotherapists not being allowed to treat patients unless referred by a doctor or dentist, but one of how physiotherapists developed their understanding of their role within medicine and society.

Writers such as Friedson, Ehrenreich, and Zola have studied the place of medicine in society and the way organised medicine achieved domination of the healing professions. Friedson (1970) notes the problems doctors had in coming to terms with other healers. They faced the dilemma of wanting and needing the services offered by alternative healers, but fearing their expansion if not controlled by the medical profession. Miles-Tapping (1985) identified three forms of medical dominance that have been studied by many sociologists - subordination, limitation and exclusion. Physiotherapy was controlled by being made subordinate to medicine.

Friedson argues that in the medical model of disease the functions of diagnosis and treatment are paramount and put the doctor firmly in charge. Other tasks, carried out by other workers, are seen to assist in these primary functions of medicine and the people who carry out these subordinate tasks are therefore subordinate to the doctor. The occupations defined as subordinate had a choice. Some, including physiotherapy and dentistry, accepted medical dominance. Others such as osteopathy did not and were marginalised as 'quacks'. In particular, they were denied access to patients within the National Health Service and so their effective practice was reduced.
Miles-Tapping (1985) illustrates the reality of this choice by arguing that dentists were an occupational group potentially in direct competition with doctors. By accepting the medical model of disease based on the germ theory and limiting their treatment to a specific part of the body, dentists avoided conflict with the medical profession and benefited from the high status society awarded doctors.

Osteopaths (in the United Kingdom) and chiropractors (in Canada) resisted medical dominance. Because they refused to accept medical theories of disease osteopaths were denied medical recognition. Although their practice of manipulative procedures connected them closely to physiotherapy, their refusal denied them the legitimacy of orthodox medicine. It did however, allow them to develop alternative theories. Larkin (1983) recognises the threat alternative medical theories pose to the medical profession. In his study of occupational monopoly he argues that physiotherapists had to distance themselves from any alternative medicine:

> "The medical profession has sought out the skills of the physiotherapist provided that they were uncontaminated by osteopathic concepts of pathology." (Larkin 1983 p93).

Miles-Tapping discusses the similar case of chiropractors in Canada who refused to accept medical control of their knowledge base. They have not been controlled by medicine and have therefore been free to select their own definitions of what constitutes knowledge and reality. It is, according to Miles-Tapping, this control of the knowledge base that is the key to medicine's control of the paramedical professions. By insisting that physiotherapy practice is judged by its 'scientific' worth and that only scientific facts are legitimate, doctors assert their dominance over physiotherapy:

> "As long as the physiotherapy profession rests its body of knowledge and practice on the medical model, it will continue to be subjected to medical dominance." (Miles-Tapping 1985 p293)

The similarity of the physiotherapy and nursing profession in their subordination to medicine is noted by Friedson (1970). In discussing the ways in which healing professions coped with the increase in medical dominance he argues that while some such as dentistry managed to remain fairly independent of medicine, some became fully integrated and were taken over by the doctor while others such as nursing

accepted medical dominance. This allowed them to still carry out their essential functions but firmly under medical control.

Jones (1991) claims that physiotherapy as a profession has moved significantly along the continuum of professionalisation. He includes the existence of a discrete body of knowledge and area of practice, and the existence of systematic theory as prerequisites of professionalisation that have been met by physiotherapy. He argues that it is through management structures that physiotherapy will attain and retain its professional autonomy and perceives the move to non-physiotherapy management of physiotherapy services to be the biggest threat to the autonomous and independent practice of physiotherapy.

The Tunbridge report (DHSS 1972) certainly reinforced the dominance of the medical profession in the management, supervision and clinical practice of physiotherapy. This provided the structure through which medicine could continue its control. However, the weakening of this structure envisaged in the McMillan report (DHSS 1973) and the acknowledgement that senior members of the physiotherapy profession were able to organise their own departments did not remove this control. Jones claims that the McMillan report demonstrated a "quantum leap" in official attitudes towards the remedial professions. However, it is difficult to see this report as a watershed when it still placed the organisation of physiotherapy departments 'within the framework set by a consultant', and still promoted the idea of medically orientated physiotherapy practice.

2.4 Education, Specialities and Specialisms

The historical account of the development of organised physiotherapy practice in this country demonstrates quite clearly that those women hailed as the founders of the profession accepted medical patronage in order to gain respectability at the turn of the

century. They allied themselves with orthodox medicine and thus, knowingly or not, gave up control of the knowledge base of their profession. The increasing hegemony of medicine boosted the status of those professions that chose to ally themselves to it, but restricted their autonomous development. Larkin identified the discontent that this was causing by the early 1940's:

> "Thus by the early 1940's the two extreme factions within the Chartered Soceity were bitterly divided. One group argued that the link with the medical profession had brought nothing but harm, whilst the leadership group suggested the opposite." Larkin (1983 p119).

Acceptance of the medical model meant subordination of physiotherapy to the key medical functions of diagnosis and cure and prevented significant progress being made towards the articulation of physiotherapy's unique knowledge base. Larkin (1983) notes the British Medical Journal's warning in 1948 against the lessening of medical control which was clearly needed to prevent physiotherapists developing a pathological and therapeutic system of their own like osteopathy (BMJ 1948).

Two key issues that need to be explored further to examine the practice of physiotherapy are the growth in the hegemony of medicine in the 19th and 20th centuries, and the role of women in the society of that period. The link between the development of the organised practice of physiotherapy and the medical profession has been shown through the history of the Chartered Society of Physiotherapy. An examination therefore of the growth in influence of medicine in society will illuminate the relationship between the two professions. As a mainly female profession, which actively excluded men from its ranks until the 1920's, an examination of the attitudes of society towards women's role in the relationship between medicine and society will again illuminate some of the issues that have influenced the development of the physiotherapy profession.

Larkin (1984) identified the political processes of role construction with his claim that

the incorporation of physiotherapists into what he terms the modern medical division of labour was through a system of patronage which reflected medical interests and

> "that the character and boundaries of physiotherapists' knowledge and training have been extensively affected by what was permitted rather than by what was desired." (Larkin 1983 p124)

The argument that physiotherapy's domination by medicine continues in spite of organisational and legislative changes and is because of its continuing reliance on medical theory for its knowledge base is developed further at a later stage. An examination of the theoretical models of health that are available to the profession together with a discussion on the reasons why these alternative models have not been taken up by the profession is a later part of this thesis.

Physiotherapy Education

Significant changes in the way physiotherapists were educated took place between 1974 and 1997. This period was characterised by move from diplomate profession to all graduate profession and by the continuing debate over the relationship between formal classroom based learning and learning through clinical practice.

In 1970 the policy of the Chartered Society of Physiotherapy was to encourage the development of a limited number of degree courses so as to have a small number of graduates in the profession. There were strong arguments put forward against an all graduate profession and there was uncertainty about the value of degree courses for all in a profession where the "practical applications of skills is so important." (Piercy 1979).

Piercy argued that the profession must revisit the arguments and base its decision, hopefully for an all graduate profession, on giving improved care to patients. She acknowledged the very real and widely held concerns that "the trend to transfer to higher educational institutions will separate the clinical and educational components of

the course." This fear of separateness was to become a recurring theme right through to the development of the 1996 Curriculum Framework. However Piercy (1979) refers to a CPSM working party on higher and further education and supports one of their main arguments in favour of an all graduate profession:

> "The purpose of physiotherapy education is to produce skilled clinicians, who are capable of a critical approach to their work in order to form decisions and achieve the most effective results." (Piercy 1979 p186)

In November 1979 the CSP Education Committee issued a policy statement in favour of all degree courses. The emphasis was on the importance of developing a critical, evaluative approach to practice and practitioners who would regard learning as a life-long process:

> "We see no service needs, other than those fulfilled by helpers which do not require the critical, evaluative approach to professional skills acquired during a degree level professional course." (CSP 1979)

> "The values and skills associated with critical evaluation, analysis, development and innovation must become a part of the preparation of the physiotherapist. Degree courses in physiotherapy would provide these skills and would provide ready access to instruction, expertise and facilities for post-graduate studies." (CSP 1979)

In 1980 the first British graduates in physiotherapy completed the 4 year course at Ulster Polytechnic's School of Health Sciences. (Barclay 1994). In 1981 the London Hospital School of Physiotherapy took in its first students for the BSc physiotherapy course and following these successes the CSP put the case for an all-graduate profession to the Minister of State for Social Security in 1981.

Funding constraints were used by the government to restrict the setting up of any further degree courses for physiotherapy in England and Wales. Edinburgh, Glasgow and Ulster however were not included under this embargo and developments

continued, with Queen's College Glasgow and two schools in the Republic of Ireland gaining approval for degree status in 1982 and 1983. The reason for the government embargo is believed by some to have been due to the beliefs of Sir Keith Joseph (first as Minister of State for Health, then Secretary of State for Education) who would not agree to any further degree courses for professions covered by the CPSM Act. In his view these professions were not academic subjects so should not be studied at degree level. This prejudice was never publicly articulated or put into policy statements, but was used to influence Privy Council (Larkin 1997 personal statement).

During the period of the moratorium an argument had been constructed around whether physiotherapy courses should be 3 years or 4 years in length. The need to resolve this was one reason given for not funding English and Welsh degree courses. The argument hinged on whether clinical education could count towards an academic award, as claimed by Brook and Parry (1988) or whether 1000 hours had to be additional to 3 years academic study as in the Ulster model. This was resolved by 1996 when the new Curriculum Framework adopted an integrated approach between clinical components and theoretical basis and therefore between clinicians and university lecturers (Brook 1996).

> "The curriculum is based on the notion that the learning achieved by students in university and clinical settings is of equal educational significance and should be wholly integrated." (CSP 1996 p8)

However, the arguments within the profession over the desirability of an all degree profession had not been totally won. In 1986 List argued against move to Higher Education claiming that "the time has not yet come". She urged educators to move slowly and with great caution and expressed concern that it would leave the way open for others such as masseurs to replace physiotherapists in clinical practice.

In 1988 Atkinson (Atkinson 1988) pushed for physiotherapy to move into institutions of Higher Education. She refuted arguments that the development of the academic side of profession would be to detriment of clinical practice and claimed that clinical competence and intellectual development are totally inter-dependent. She articulated the need to educate rather than train physiotherapists and to develop an attitude of enquiry with research becoming a habit, a plea repeated regularly in the following years and still being made nine years later (Moore 1997).

Once Sir Keith Joseph resigned in 1989 the government embargo was lifted and "a period of explosive development in physiotherapy education followed". (Walker and Humphreys 1994). Teesside, Sheffield, Coventry and Newcastle went to degree status very quickly as these schools had used the embargo period to develop courses ready for validation. Between 1989 and 1992 twenty four physiotherapy degrees were established in the United Kingdom and the profession became all-graduate by entry in September 1992.

One of the main tensions amongst academics and clinicians throughout this period was between the desire for academic recognition and the fear of losing practical skills. These two components were not always seen as compatible. Higher education was valued as the means to develop reflective practice, a research base for profession and as a way of attracting more candidates. However, there were those whose main concern was that if physiotherapy became an academic profession it would lose its desire to do practical work which would then have to be picked up by others. This was the very argument that had persuaded Keith Joseph not to allow degree courses to be funded. It was certainly acknowledged that the mere acquisition of a large body of knowledge would be no assurance that patient care would benefit. (Richardson 1992).

A key way of ensuring that the link between academic learning and clinical practice was enhanced was the ongoing commitment to 1000 hours of supervised clinical

practice. (McCoy 1991, CSP 1996). However one of the issues to arise out of the consultative conference on the 1996 Curriculum Framework was the anomaly of a framework that was focused on outcome rather than process yet still had a quantitative requirement for its clinical component. That anomaly was recognised and assurance given by the Director of Education (Alan Walker) that the review of clinical education which was ongoing would address the outcome versus process issue.

Discussion

The changes in physiotherapy education were to a large extent driven by external factors. Once physiotherapy had entered the Higher Education arena it was subject to forces which as a professionally controlled and highly centralised system it had hitherto avoided. Moreover it was educating a workforce for a marketplace which was itself undergoing massive structural and cultural changes. These two factors forced physiotherapy education to rapidly make up the time it had lost during the Keith Joseph moratorium.

> "Over the past ten years the NHS has been subject to constant and relentless change. Health care education, by its very nature, cannot fail to to be influenced by the changes occurring within the NHS, but is also affected by changes in the wider field of education." (Quinn 1994 p27)

Specialities and Specialisms

The aim of this section is to demonstrate the dominance of the reductionist model of medicine in the practice of physiotherapy. An exploration of the structure of the pre-registration clinical education of physiotherapists and the major changes in the delivery of this from 1974 to 1996, and of the first two years of post-registration practice is used to illustrate this. Increasing specialisation after this initial period gives

rise to tensions and conflicts not previously evident and these are explored through the formation of the special interest groups. Their development since 1986 is outlined and this is linked to internal and external pressures for specialisation.

Medical specialisation and physiotherapy

One of the manifestations of the domination of physiotherapy by medicine is in the way in which the development of medical specialities has been closely followed by the development of complementary physiotherapy specialities. The reductionist approach integral to medicine is mirrored by physiotherapy through a pragmatic approach to move with doctors into ever expanding areas of medical influence. Thus when geriatrics became an acceptable medical speciality physiotherapists began to develop skills specific to their work with elderly people and to promulgate the view that geriatrics was a specialist area of work for physiotherapists. A special interest group of physiotherapists working in this field (Association of Physiotherapists in Geriatric Medicine) was formed and experience of working in geriatrics became a requirement at both pre and post registration level.

A list of the areas of medical specialisation can be matched to a large extent by a list of areas claimed by physiotherapists to be legitimate physiotherapy specialities. Special interest groups exist in these areas and all are either mandatory or specified optional areas of physiotherapy education and practice at pre and post registration level. Orthopaedic medicine, paediatrics, psychiatry, neurology, geriatrics, rheumatology, cardio-thoracic medicine, and respiratory medicine all fit this pattern. (Exceptions are some organ related specialist areas such as ophthalmology and ear, nose and throat medicine.)

It would appear that there are two ways in which an area of physiotherapy practice becomes recognised as a specialism. One is through the rotation system set up for pre-registration education and for the two years immediately following registration. The

other is the special or clinical interest groups.

Pre-registration clinical practice

Physiotherapy registration requires 1000 hours of clinical practice - almost all of which is organised within the National Health Service in, or under the auspices of, large general hospitals. The accepted model is for a physiotherapy student to spend periods of time in college learning theoretical and practical physiotherapy skills interspersed with time applying those skills, under supervision, in a clinical setting. The 1984 Curriculum of Study (CSP 1984) describes the clinical education placements as providing the integrating element in physiotherapy education. Similarly the 1991 Curriculum of Study (CSP 1991) states that clinical education provides the focus for the integration of the knowledge and skills learnt at the college base. In 1984 the curriculum stated that clinical experience through clinical placements must be gained in seven areas - all of which are medical specialities: Cardio-vascular disorders, General surgery, Geriatrics, Neurology, Orthopaedics and trauma, Respiratory disorders including intensive care, and Rheumatology. Additional areas, for inclusion where possible but not considered essential, were: Advanced rehabilitation, Burns and plastic surgery, Mental handicap, Mental illness, Obstetrics and gynaecology, Paediatrics, Physical handicap, Remedial pools, Spinal injuries. All of these, with the exception of 'Remedial pools', are medical specialities.

The 1991 curriculum is not quite so prescriptive. The equivalent section requires that clinical placements should be arranged to give experience in: "a wide range of patients suffering from disorders of the neuromuscular, musculoskeletal, and cardio-vascular and respiratory systems." These areas are not such discrete areas of medical specialisation but offer a broader perspective of medical practice. The significance of the choice of systems of the human body (neuromuscular, musculoskeletal, cardio-vascular and respiratory) as the main areas within which clinical placements should be arranged is that these systems spring from the reductionist approach of the

bio-medical model. The choice could have been to use age- related groups of people - elderly, young disabled, paediatrics - within which to organise the practice of physiotherapy skills. Another alternative would have been the use of the setting to determine the practice - hospital, home, industry, schools. Mention is made in the curriculum of the setting - health centres, daycare centres, etc. but the overall classification of the practice of physiotherapy is a medical one.

1996 Curriculum Framework

The result of this sub-division of pre-registration physiotherapy clinical practice into medically defined areas is that the theory and assumptions that have led to the development of contemporary medical practice have become a major influence on physiotherapy students. The culture of clinical practice is held by educationalists to be a key component of physiotherapy education, and this culture is essentially that of a health service dominated by medicine and by the assumptions of the medical model.

There is no evidence that the possibility of using a non-medical theoretical framework within which to teach physiotherapy has been considered by any of the groups that have been set up to review physiotherapy education. The practice of physiotherapy from the very start of the pre-registration stage is bound closely to medical model assumptions; clinical practice influences the development of physiotherapy education which in turn reinforces the medical model as the basis for clinical practice.

Post-registration - the early years

The initial years of post-registration practice are seen by the profession as a critical time in the development of physiotherapists. It is commonly viewed as a probationary period of assimilation allowing the newly qualified physiotherapist to build on the foundation laid during training. The reduction of the clinical hours component of pre-registration education from 1500 hours in 1984 to 1000 hours in 1991 has reinforced the concept of these first years of practice as being essential to the development of

adequate professional skills. There has been a growth in the demand for a formalisation of this probationary period (CSP 1992a). It is the practical difficulties of implementing such a probationary period that has led to the idea being rejected centrally. The principle of such a period, which is common in other professions, is held to be sound. The 1996 report on newly qualified physiotherapists recognised that a quantitative requirement to complete two years at junior grade in order to consolidate prior learning was meaningless as some individuals would develop more quickly than others. So while it endorsed the concept of a post-registration period it did not prescribe a set time. (CSP 1996).

These early years are traditionally spent working in a large general hospital on a rotation scheme. Rotations are worked for three months at a time and in largely the areas covered as a student. The practice is that of a qualified physiotherapist rather than a student but the reinforcement is the same - that clinical practice is grounded in medical specialties. The work is also carried out in the same medically dominated culture and it is a firmly held belief amongst physiotherapists that a sound grounding in all medical areas is necessary before branching out to work in non medically dominated areas such as the community (CSP 1992a).

Pressure to conform to this model comes from the central body which will strongly advise physiotherapists requesting information about non traditional practice options to complete a two year rotation period in a large district general hospital first. Physiotherapists have been discouraged from going abroad in this period although recently this advice has been tempered. They are now advised to seek employment abroad only if a similar rotation scheme can be offered - the United States of America, Canada, Australia and New Zealand are considered suitable - while third-world countries would be seen as unable to offer the newly qualified practitioner an appropriate probationary period. The socialisation of physiotherapists as health workers within the medical model is therefore continued during this period with

reinforcement from colleagues, hospital structures, physiotherapy managers responsible for rotation schemes, and the professional body.

There does not appear to be any evidence of dissatisfaction at this stage with the domination of physiotherapy by medicine. Students and newly qualified physiotherapists appear to accept the commitment to the medical model of health care. There is, as has been demonstrated above, a strong socialisation period in which many factors operate. The structure within which clinical skills are practised is medically defined, and the process of this practice is dominated by the hegemony of medicine.

Clinical Interest Groups

The first two years of post-registration clinical practice are graded at the lowest level of pay - junior grade (previously called basic-grade). No figures are available but it is generally considered that all but a very few physiotherapists conform to this model and spend eighteen months to two years on a junior rotation scheme. The structure after that is Senior 2 which marks the beginning of specialisation, Senior 1 in an established speciality, and then a move into management grades (Superintendent 3, 2 and 1,). A physiotherapist working at Superintendent 3 level would be expected to retain a significant clinical workload, but Senior 1 is considered to be the top of the clinical grades and one to which most physiotherapists aspire.

Throughout the progression from junior to Senior 1 the emphasis is on narrowing the field of expertise to a single speciality. A Senior 1 has to be a Senior 1 in a named field such as orthopaedics, neurology, respiratory care or paediatrics. The pattern is again that of medical specialties. As physiotherapy practice established itself in these areas complementary special interest groups emerged. The pressure behind the formation of individual special interest groups varied. For some the desire to share knowledge and experience with physiotherapists working in the same field was paramount. For others it was a way of pushing physiotherapy into areas not traditionally part of a rotation scheme. Breaking new ground was resisted sometimes

from within the profession, sometimes from without, usually by factions from both.

The Recognition Process

In 1985 a decision was taken by the central professional body to 'recognise' the special interest groups that had formed within the profession. At an early stage a differentiation was made between special interest groups that were occupationally based - private practitioners, physiotherapists working in industry, independent hospitals, teachers and managers - and those that were formed out of a common clinical interest. These latter were the clinical interest groups.

Recognition was seen as desirable for different reasons by different parties. The request from the groups was for more central support, particularly in the administrative aspects of running groups which had growing national and regional membership, annual conferences and newsletters. The groups wanted this support supplied centrally or for money in the form of a capitation fee to be allocated to them to purchase it. The central body resisted this and there is evidence throughout the history of the clinical group conferences and the recognition process that the main motive of the establishment was to find a way of controlling and containing the emerging special interest groups.

Clinical Interest Group Conferences

These annual conferences started in 1986 and arose ostensibly out of the need of the central organisation (the CSP) to address the issue of post-registration specialisation of the profession. The dominant theme of the early conferences (notably 1986, 1987 and 1988) was the control and limitation of the development of clinical interest groups. A moratorium was put on the emergence of any new groups (although as these groups were essentially groups of physiotherapists with common interests getting together for mutual support it is difficult to see how such a moratorium could ever have been enforced) and there was strong pressure, culminating at the 1988 conference, for three

or four specialist areas to be identified, based on a reductionist model of the human body. The pressure for specialisation along medical lines came from several sources within the structure of the central professional body. For educationalists involved with the review of the curriculum, specialisation was necessary to regularise post-qualification education:

> "The Review Committee sees an urgent need to establish proper mechanisms for post-qualification education to assure continued personal and professional development and the further development of specialisms."

> "Practical aspects of the collegiate role necessitate that the professional body takes a leading part in matters such as specialisation and the formulation of its components and in the monitoring of post-qualification educational opportunities."

> (CSP 1983)

Those involved in clinical practice wanted the profession to make a decision on where it stood on specialisation to clarify the situation of the special interest groups:

> "Several groups would welcome a stronger lead from the CSP with regard to the development of SIGs and specialisms."

> "It should be for the profession to identify specialisms, of which there can only be a few."

> (CSP1985)

> "It seems that the Society needs to identify the core skills of the profession and develop specialisms based on these core subjects. The Society should concentrate its efforts and resources on developing these professional specialisms."

> "The major decision to be taken is how the specialisms are to be clearly identified, and by whom; and how this marries with the existing specific interest group structure." (CSP 1986a)

Opposition to the Medical Model

It is clear that within the profession there is a substantial body of opinion in favour of specialisation along medical lines. Equally, some physiotherapists, and the critical factor appears to be their chosen area of clinical practice, find great problems with the idea of physiotherapy specialisms which match those in the medical field. They are strongly opposed to any limitation of physiotherapy practice to a few all-encompassing systems-based specialisms. These are physiotherapists whose practice has developed away from direct medical influence and may be based on alternative, non-medical, models of care.

In 1986, at the first conference for clinical interest groups, this opposition was recorded in the report. This report concluded that the development of specialisms in physiotherapy must be from the grassroots up. A clear message was sent to the CSP that it must be supportive and not heavy handed. The following quotes from that report illustrate that message:

> "Pioneers must be allowed to ride out to frontiers, gather their disciples around them, and return for acceptance when they have gathered sufficient strength."
>
> "Specific interest groups must not be restricted - if they are not needed (by the profession) they will soon die from lack of support - if they are they will grow and flourish."
>
> "the profession must not fall into the trap of over-specialisation."
>
> "the profession need not agonise over whether SIGS should be client or skills based...overlap does not matter."
>
> "The scope of the profession is currently defined by specific interest groups. If the development of specific interest groups is made to fossilise - as currently with the moratorium on the formation of further groups - the profession itself will fossilise. The system must be flexible to allow for evolution." (CSP 1986b)

The Association of Chartered Physiotherapists with a Special Interest in Elderly People (ACPSIEP) and the Association of Chartered Physiotherapists in Neurology (ACPIN) formed an unexpected alliance to resist the move to medical specialities. This alliance was unexpected as ACPSIEP considered itself a non-medical speciality and ACPIN a medical speciality. An examination of the development of two specialities and their relationship to associated medical practice may provide an explanation for this.

The 1986 conference agreed the following recognition criteria -

> 1. That the groups have a minimum of 50 signatures of Chartered Physiotherapists committed to join a particular clinical interest group.
>
> 2. That the proposed group provides for a clinical area of physiotherapy or client group that has minimal overlap with other physiotherapy or client groups.
>
> 3. That the group demonstrates a commitment to developing an area of expertise by education, practice and research, which will benefit both the profession as a whole and the general public.
>
> 4. That the group demonstrates a clear and valid relationship between the area of expertise/specialism and the core of physiotherapy as described in the Charter. (CSP 1986b)

Verbal reports from the conference indicate that there was considerable disquiet about criterion 2 which stated that there should be minimal overlap between groups. The special interest group for elderly people (ACPSIEP) were very unhappy with this criterion and claimed they had received a commitment at the conference that this would be amended and that they had support from the neurology group (ACPIN). The conference report does note that the question of overlap between the groups needs to be addressed urgently but the criteria as above went forward to the Membership Services and Public Relations Committee (a standing committee of the CSP's Council)

and were accepted as they stood. The resultant refusal of ACPSIEP to apply for recognition caused some embarrassment as this was one of the largest and most active of the profession's clinical interest groups, representing a significant part of the practice of physiotherapy. It was not until 1990 that the matter was resolved - the offending criterion was reworded to read:

> " That the proposed group provides for a distinct clinical area or client group for physiotherapy".

The basis for ACPSIEP's objection to the term 'minimal overlap' was that its members believed this to be an attempt to compartmentalise physiotherapy into discrete specialities. This they claimed was contrary to the spirit of the 1986 conference which had stressed the importance of flexibility, and was also contrary to their own philosophy which was one of maximal overlap with other groups - both client based such as community physiotherapists, clinical speciality based such as respiratory physiotherapists, and skills based such as the acupuncture association. These arguments were eventually accepted by the Professional Practice Committee (the standing committee which took over responsibility for professional issues when the Membership Services and Public Relations Committee was disbanded in 1987); the criteria were amended; ACPSIEP applied for, and was granted, recognition.

This two year fight ACPSIEP had to effect a change in the recognition criteria, supported by other groups who did not choose to refuse to apply for recognition but nonetheless supported ACPSIEP in its struggle, illustrates the tension that was created by the centralised power base of the CSP attempting to impose a structure on the CIGs with which they were not comfortable. The attempt to compartmentalise the practice of physiotherapy into discrete specialities with minimal overlap conflicted with the desire of the physiotherapists not to fall into the reductionist model of specialisation inherent in the medical system. It would appear therefore that within the clinical practice of some physiotherapists there is a need to work within a non-medical

framework, to reject specialisation based on a reductionist approach. A client-based model - age related - does not appear to give rise to so much tension, and seems to sit comfortably alongside skills based divisions. Indeed the 1986 conference had suggested a model based on a simple matrix which would encompass all groups. A later development of this matrix into a three-dimensional one was not well received as it incorporated a systems based division with which the groups were not comfortable. The body systems which were chosen to cover all practice of physiotherapy were cardio-respiratory, musculo-skeletal and neuro-muscular. This was too much of a reductionist approach for those groups who were resisting a medical model of specialisation and although still a model which is referred to has never formed the basis for development either of specialisms or of clinical interest groups.

However, there were, and still are, significant groups of physiotherapists for whom the medical model of specialisation remains a legitimate goal. These groups are attracted both by the logic of continuing to develop their own practice alongside that of their medical colleagues and see no inherent problem with doing so, and by the increased status such a specialisation could offer. Proponents of this argue that the experience of physiotherapists in Australia is that specialisation along medical lines has led to a significant increase in the status awarded to physiotherapists by doctors and thus by society as a whole.

The groups that support medically based specialities in physiotherapy are those that work most closely with doctors in their practice of physiotherapy. Notably they are the Manipulation Association of Chartered Physiotherapists (MACP) and the Association of Orthopaedic Chartered Physiotherapists (AOCP). These groups are comfortable with their close liaison with the medical profession and would not consider it to threaten their autonomy as practitioners. It could be argued however, that it is their very closeness to the medical profession that prevents them seeing any domination.

The Development of Individual Clinical Interest Groups

Different models of clinical interest groups had emerged by the time of the first annual conference in 1986. Some were client based, some modality based, and others were based on biological systems. This latter was the model most favoured by the establishment grouping as it was closely allied to medicine and was seen to give the profession status with the doctors. An examination of some of the individual groups illustrates the variable nature of the relationship between these groups and medicine. It also demonstrates the resistance to the formation of some of the less traditional ie. non-medical based groups.

Physiotherapy in Orthopaedics

Orthopaedic physiotherapy practice is closely defined by doctors. The procedures carried out by physiotherapists following orthopaedic operations are controlled by the consultant surgeon. A particular operation, often named after the originator of the procedure, will have a set regime of physiotherapy to be followed post-operatively. There may, in some cases, be extensive involvement of physiotherapists in the development and agreement of the regime, but it is clear that the doctor is in control at all stages and that the post-operative treatment is determined more by the surgical procedure that has been carried out than by factors relating to an individual patient. The development of physiotherapy practice within this field is therefore constrained within closely defined limits and is controlled by medical practice. If no more orthopaedic procedures were carried out for whatever reason then associated physiotherapy practice would have to cease. Physiotherapists could no longer carry on doing what they currently do now as this is so closely tied to medicine.

Physiotherapy in Neurology

In contrast to orthopaedics, physiotherapists working in the field of neurology have developed practice independent of medicine. Physiotherapists working with people who have a neurological deficit resulting from multiple sclerosis, a cerebro-vascular

accident or Parkinson's disease for instance, do not rely on regimes or procedures controlled by doctors. The theory behind their practice, while not being at odds with medical theory, has to a great extent been based on the clinical experience and observation of physiotherapists rather than as an adjunct to medicine. Physiotherapists in this field are not dependent on the existence or practice of neurologists for their work. If there were no more neurologists physiotherapists would to a large extent be able to carry on doing what they do now as their practice is not closely tied to medicine.

Physiotherapy in neurology therefore, although bearing the name of a medical speciality, is not allied to medicine in the same way as some of the other physiotherapy specialisms such as orthopaedics. Physiotherapy practice in this field exists in its own right and a closer relationship with medicine could threaten the autonomy of this practice while offering no benefits. It may be for this reason that ACPIN is one of the clinical interest groups that has always strongly resisted the categorisation of the profession into medical specialities. Their representative at the 1992 Annual Representatives' Conference in Glasgow spoke against the following motion:

> "The Chartered Society should establish a working party to determine the criteria for the use of the term 'specialist' within the profession." (CSP 1992b)

Nina Melville of ACPIN (Association of Chartered Physiotherapists in Neurology) speaking against the motion said she appreciated the importance of specialisation and the development of clinical skills to a high standard but questioned the wish to see a profession "divided entirely into small elite groups". The motion was narrowly lost. (CSP 1992b).

Physiotherapy with Elderly People

The Association of Physiotherapists in Geriatric Medicine was formed to legitimise and promulgate the practice of physiotherapy in the newly developed medical specialty

of geriatric medicine. It met little overt resistance and is one of the largest and most active of the clinical interest groups. It changed its name to the Association of Chartered Physiotherapists with a Special Interest in Elderly People at a time when the term geriatrics was seen to be derogatory, and to reflect its then wider interest in the care of elderly people outside the narrow area of geriatric medicine. Covert resistance was met within the profession as geriatrics was not seen as a worthwhile area of practice. It retains even today an image of not being a demanding specialty, not `high-tec` and not requiring a lot of post-graduate skills. Those working within the specialty dispute this and have to a large extent been successful in making the care of elderly people a more attractive proposition for physiotherapists. This may in fact be a necessity given the demographic changes of the population and the fact that most physiotherapy is carried out with patients who fall within the classification of elderly.

Acupuncture and Reflexology

A group which met great resistance and which had to work hard to legitimise itself was the Acupuncture Association. This was the first group to venture outside traditional or orthodox (as defined by the medical profession) physiotherapy and claim a new modality as legitimate practice. Arguments against its adoption by physiotherapists were about relating it to the core of physiotherapy.

To be recognised as legitimate physiotherapy practice a modality has to be related to one or more of the three elements named in the Charter granted in 1924. These three elements are massage, movement, and electrotherapy. There are other requirements relating to the benefits of a modality to patients, but as far as acupuncture was concerned those arguing against it becoming a recognised physiotherapy modality did so on the basis of a lack of connection with the three core elements. In addition it was argued that it meant entering a new area - that of intrusion into the body. Physiotherapy is a practice which on the whole does not involve intrusive techniques such as breaking the skin. Supporters of the practice of acupuncture by

physiotherapists argued that other forms of intrusion are practised by physiotherapists such as the introduction of ultra-violet applicators or faradic electrodes into body spaces. These arguments won the day. However, recognition has not completely quenched the flames and there is still a substantial minority of physiotherapists who do not consider acupuncture to be a legitimate physiotherapy modality.

Reflexology is more closely linked with the core of physiotherapy practice than acupuncture as it involves massage, but its use is more greatly resisted. Acupuncture is beginning to be explained in western terms - medicine has adopted the practice and is developing theories to suit. Once doctors have accepted a scientific basis for the use of a modality it is legitimised for physiotherapy practice. Reflexology is not yet at that stage and physiotherapists are therefore not so confident about adopting it. The arguments against introducing it into physiotherapy revolve around its safety as it is more difficult for its opponents to argue that it is not related to the core practice of physiotherapy.

Discussion

The failure of the medical model to be accepted by the profession as represented at the conferences is indicative of the incompleteness of the domination of physiotherapy by medicine. If the clinical interest groups are considered to be the self-identified areas of physiotherapy specialisation, then their resistance to adopt medical specialisms is indicative of the existence of physiotherapy practice which is outside the medical model. However it is clear that not all physiotherapists reject the model of medical specialisation as relevant to physiotherapy.

After the 1988 conference there was a period of four years during which the pressure relaxed. However, in 1992 there were moves to resolve the issue of the promulgation of clinical interest groups again by only allowing the existence of a few within a

collegiate system. This has received a set back with the defeat of the motion at the 1992 representatives' conference . To date therefore, the pressure has been resisted and ways have been found of reconciling the desire of the central body to control these groups with the resistance of the groups themselves to be forced into an artificial structure. This may indicate the dominance of those groups which are against specialisation along medical grounds. Certainly, the call for specialisation in order to raise the status of physiotherapy in the eyes of the medical profession is seen as less legitimate than it was in 1987 and the need to contextualise practice is being recognised:

> "....physiotherapists must now be able to clarify the implications of their practice within a variety of settings and to present both their profession and their own particular skills and competence in a competitive world of health care." (Richardson 1992 p24).

2.5 The Development of Medicine and Physiotherapy

This section briefly outlines the evolution of organised medicine in this country by tracing key events in the area of the care of elderly people. The emergence of departments of geriatric medicine is described as pre-empting the acceptance of geriatrics as a medical speciality following the Second World War. The development of physiotherapy practice alongside this newly emerged speciality is examined and the resulting potential for conflict. The organisation of hospital-based multi-disciplinary clinical teams is then described to illustrate some of the pertinent conflicts within the delivery of health care. One source of this conflict is the belief of doctors that their scientific knowledge base renders them natural team leaders while other health care professionals regard team members as equals.

The second part of this section argues that the development of organised medicine, the parallel development of physiotherapy, and multi-disciplinary teams are all based on the idea that male, scientifically based medical practice is superior to other forms of health care. The work of feminist writers is used to explore the relationship between physiotherapy, which is a predominantly female profession, and medicine.

The Care of Elderly People in Hospital

The history of health care in the United Kingdom has been well documented by such authors as Bruce (1968), Fraser (1984) and Bullough and Bullough (1979). A brief outline of this is given here to demonstrate the development of the speciality of geriatric medicine and the link with physiotherapy.

Prior to the reformation, centralised health care - rather than that carried out at home - was focused in the monasteries. After dissolution virtually all forms of hospitals disappeared in this country until 1691 when the Poor Relief Act was passed and poorhouses were built for the custodial care of "derelict human beings". In 1834 the

Poor Law Amendment Act established workhouses which were administered by Boards of Guardians. These were subject to the principle of 'less eligibility' whereby those given relief should not experience conditions of life as good as or better than those experienced by 'an independent labourer of the lowest class'. The criteria for admission was poverty regardless of age, class or health status.

Bruce (1968) traces the beginnings of an embryonic hospital service to 1867. Unions everywhere were encouraged to join together to form Sick Asylum Districts large enough to support hospitals to which the sick could be removed from the workhouses. A Metropolitan Common Poor Fund was established in London for building and maintaining isolation hospitals for infectious cases, infirmaries for the non-infectious, asylums for the mentally ill and dispensaries for those who did not need admission to a bed. At first only paupers were admitted, but in 1883 the Diseases Prevention Act legalised admission to the hospitals without any question of poor-relief.

In 1909 it was estimated that 140,000 elderly people were in Poor Law institutions and conditions in some of these were grim. In a survey of institutions for the elderly Townsend (1963) describes the conditions of a turn of the century workhouse and notes that the inmates were:

> "over 900 in number and were congregated in large rooms without any attempt to employ their time ... it could be better described as a human warehouse...the dormitories so full of beds as to make it impossible to provide chairs or to walk except sideways." (Townsend 1963 p69).

The end of the 19th century saw the rapid growth of medical science and the development of the voluntary hospital system. Hospitals became centres of medical teaching and research. They began to be distinguished by medical speciality such as dermatology, eye diseases, paediatrics, infectious diseases.

In 1929 Public Assistance Committees took over the management of workhouses. Authorities were encouraged to co-ordinate their various services and institutions and a great extension of hospital facilities followed. (Bruce 1968). By 1939 there were 400 old-type workhouses with 60,000 beds, municipal hospitals under public health control with 70,000 beds, and another 70,000 beds in voluntary hospitals. The municipal hospitals dealt mainly with the chronic sick most of whom were elderly. The voluntary hospitals dealt with acute medical and surgical illness.

Until 1930 little thought was given to the concept of rehabilitation in the municipal hospitals. Hawker (1974) refers to the work of the early geriatricians, particularly Warren who had a pioneering approach to the old institutions and showed what was possible. The Second World War saw the transfer of many local authority institutions to the Emergency Medical Service. Bruce (1968) notes the key effect the war had on the development of geriatrics as a speciality:

> "The plight of many elderly people, especially those in institutions, who were pushed around to make room for the expected air-raid casualties, first gave the country the gerontological bias which, with the increasing proportion of old people in the community, it has since retained."
> (Bruce 1968 p305)

In 1948 the National Health Service attempted to try to co-ordinate all aspects of health care 'from cradle to grave'. The old Public Assistance institutions were designated either as hospitals under control of a health authority, or as welfare homes under local authority control. Their designation depended on the number of residents who were classed as either sick or physically fit.

Since 1948 the policy of the Department of Health and Social Security has been to establish departments of geriatric medicine throughout the United Kingdom to provide a service for elderly people needing hospital treatment (Hawker 1974). Acceptance of

geriatrics as a medical speciality was enhanced by the appointment of senior physicians to organise these departments - thereby giving the speciality of geriatrics higher status.

> "Geriatrics has now established itself as a branch of general medicine which is concerned with the clinical, preventive, remedial and social aspects of health and disability in the elderly." (Hawker 1974 p9)

Once geriatrics became established in hospital departments of geriatric medicine physiotherapists began to develop a professional base in these departments and to concentrate on treating elderly people in hospital rather than at home. In 1979 the Chartered Society of Physiotherapy's Review Committee report on domiciliary services for elderly people stated that physiotherapists should act only in an advisory and teaching capacity and not get involved in treatment. This was taken up by the Department of Health and Social Security who declared that the shortage of physiotherapists did not allow the development of domiciliary services. Williams (1985) notes that it is a historic anomaly that physiotherapy services were confined to hospitals and was based on an agreement that as a scarce resource to be rationed they should remain hospital based.

Physiotherapy practice with elderly people therefore developed as a hospital-based service. As the medical speciality of geriatrics became respectable and acquired status physiotherapists began to develop it as a physiotherapy speciality. This is in accordance with Mercer's observation that in hospital the way physiotherapy practice has developed has been dependent on medical specialisation. (Mercer 1979).

Hawker (1974) noted the potential conflict inherent in this close alliance between the development of physiotherapy and medicine:

> "Doctors are trained to understand medicine in scientific terms and many see their role solely as a curative one. Elderly people slow down the rate of turnover by blocking beds. So for them a convenient repository must be found." (Hawker 1974 p11)

This possible conflict between scientific, curative, medicine and the needs of the elderly population had been noted by Isaacs (1965):

> "...(geriatrics) was thrust up from general medicine by the heaving pressure of the aged. But it was not merely the growth of numbers of ill old people which breached the walls of the medical wards and forced the formation of a new speciality; there was also a new quality in the illnesses from which these elderly people suffered. This was an elusive quality, difficult to define, other than by its incompatibility with the highly-adapted activities of the acute medical ward." (Isaacs 1965 p235)

In 1978 the Association of Chartered Physiotherapists in Geriatric Medicine (ACPGM) was formed by Hawker and Squires. Eight years later it changed its name to the Association of Chartered Physiotherapists with a Special Interest in Elderly People, and in 1996 to AGILE. These changes acknowledged the much wider role physiotherapists had decided to take on in the care of elderly people, much of it outside medical departments of geriatric medicine. It may also be that, as observed by Mercer (1979), physiotherapists were frustrated by a lack of understanding of their role by the doctors from whom they received referrals. He noted that the professional socialisation of doctors may lead to their undervaluing physiotherapy. Negative attitudes picked up from consultants, or lack of time to learn about and understand physiotherapy may lead to a lack of awareness of the special contribution of physiotherapy.

Multi-disciplinary Clinical Teams

A review of the literature on the delivery of health care clearly shows the importance

placed on the multi- disciplinary clinical team as the most effective model for the cooperation of all professionals concerned with patient care. Care that is given by one professional in isolation from that given by others is seen as potentially causing problems and conflict for the patient and other carers. (Follis 1974, Gilmore et al 1974, Batchelor 1980, Russell and Fyfe 1985, Whitehead 1987, McFarlane 1980).

McFarlane (1980) describes the primary objective of any team as being:

> "to co-ordinate the health care given by different contributors to an individual which might otherwise remain uncoordinated or even in conflict." (McFarlane 1980 p37)

Evers (1981) argues that the idea of teamwork is an integral part of health care delivery central to the policy and practice of geriatric care. To meet the complex needs of sick elderly people requires input from many health workers including physiotherapists and nurses. The contribution of these experts must be co-ordinated if the patient's best interests are to be served.

However, problems relating to teamwork have been identified which need to be resolved if professionals are to work together effectively. Gilmore et al (1974) and Hannay (1980) identify different perceptions of professional roles and different expectations and values as being the reason for the conflict and tension they found in the teams studied. Brunning and Huffington (1985) identified role overlap and professional rivalry as leading to conflict. Furnham et al (1981) found negative perceptions of other team members existed when professionals were in competition over a field of specialisation. Liston and Docking (1985) argue that identification of the roles of each profession is essential for effective teamwork.

The importance of effective team working as the basis of the delivery of effective health care is a key driver behind the White Paper - The New NHS, Modern, Dependable (DoH 1999). Although teams have been around as long as health care was

split into separate components, there remains a strong need to identify when teams work effectively and why, as this is not the norm.

2.6 Medicine and Society

The advances in the state of health of the population of the United Kingdom during the 19th and 20th century are claimed by the medical profession to justify its intrusion into more and more areas of human activity, and the vast amounts of resources that are used to promote and support medical activity.

However, there is a body of opinion which claims that the role of medical intervention in improving the health of the population has been grossly overstated. Measures such as those taken to improve living conditions by reducing overcrowding, purifying the water supply, and raising nutritional standards, are now generally held to have contributed more to the decrease in tuberculosis, scarlet fever, cholera and other endemic diseases, than advances in medical knowledge or expertise.

Miller (1973) claims that cholera was already decreasing due to public health measures before Koch recognised the causal organism, and before Pasteur formulated the germ theory of infectious disease in 1860. Miller further claims that vaccination against smallpox was the only contribution made by medicine to the population growth of 19th century England.

Peter (1972) notes the widespread indictment of hospitals in the 17, 18 and 19 centuries as places that were more likely to spread disease than check it that there is evidence that most people who went in to hospital with one condition died from something else. He argues that things were not necessarily as bad as some accounts make out but agrees:

> "That hospitals were dreadful places, surgery was nasty and brutish, but never short from the viewpoint of the conscious patient..." Peter (1972 p103).

Ehrenreich and English (1973 and 1974) used a feminist perspective to examine the role of medicine in society. They claim that medicine interprets biology and turns it into social policy to be used by the establishment to maintain order and control. An examination of the role women have played is used by these authors to support this argument.

Ehrenreich and English claim that the sixty years following Pasteur's work on the germ theory saw medicine replace religion as the main means of social control. This period saw a pronounced shift from a religious to a bio-medical rationale for sexism and the formation of the modern medical profession - a male elite with a legal monopoly over medical practice. The 'myth of human frailty' served two purposes by disqualifying women as healers and making them highly qualified as patients.

According to these authors there was an interconnection between medicine and society's attitudes to women. As a businessman a doctor had a vested interest in keeping women in the sick role. They devised medical theories to justify women's social role, most significantly the idea of "conservation of energy". The argued that women (only their upper class patients) had to adopt an extremely passive role and not take an active part in society in order to conserve their energies for female functions such as child-bearing. The presumed scientific basis of medicine lent credibility to its judgements.

Ehrenreich and English and other writers such as Fee (1975) argue that the issue is one of the control of women. The growing dominance of medicine and its supposed scientific base allowed biology to become the controlling force that religion had once been. Biological differences between the sexes became all important and medicine

provided both a theory and a structure for women's oppression.

Women as Healers

In the introduction to Ehrenreich and English's pamphlet *Witches, Midwives and Nurses : a history of women healers,* Doyal, Rowbotham and Scott (1973) argue that history predominantly reflects the self-image of the powerful and that the scope of recorded history needs changing to include women. They are critical of Ehrenreich and English's over-simplification of the role of women healers and their persecution as witches, but claim that the pamphlet is still a useful tool for examining the role of women in society. They stress the importance of women using history to understand the relationship between medicine and the wider social and economic system of which it is a part.

> "Sexism does not exist because male doctors are nasty, but because patriarchy plays a particular role in the ideological underpinning of capitalism, and because capitalism needs effectively to reproduce women as wage labourers and also as domestic labourers."
> (Doyal et al 1973 p9)

They support Ehrenreich and English's assertion that women have, in the past, played a much greater role as healers than they do in this century. Until the emergence of scientific medicine in the late 18th and early 19th century a wide range of healers performed medical tasks. Talbot (1978) notes the important role women played in medicine and the long history of women as midwives. In the 13 century there were women physicians, surgeons and apothecaries (Talbot 1978). McLean (1972) notes that in the 16 century by far the largest part of medicine was home medicine. While control of centralised medicine lay with the male clergy, home medicine was largely administered by women.

Medicine and religion were interwoven and healing was not confined to one professional group. Ehrenreich and English claim that a partnership between the

Church, the state and the medical profession set out to deliberately exclude women from healing and claim it as a male prerogative. Male, upper class healing under the auspices of the Church became acceptable, female healing as part of a peasant subculture was not. Doyal, Rowbotham and Scott support the view that medicine was, and is, used to oppress through sexism and on a class basis. Male professionals served the ruling classes - both medically and politically. Witch hunts were an expression of the misogyny of the Church which supported the male establishment and actively sought to destroy the culture of female healing, particularly as it was successful:

> "It were a thousand times better for the land if all witches, but especially the blessing witch were to suffer death." (unsourced quote from Ehrenreich and English 1973).

It appears that women healers, labelled witches by the Church, had pharmacological knowledge and remedies, an empirical approach, believed in trial and error and adopted an actively enquiring approach to healing. The Church was deeply anti-empirical and fearful of organised insurrection. It regarded women healers as a source of such insurrection and was prepared to join forces with other powerful factions to repress it.

The combined efforts of the Church, the state and the medical profession led to a division between those who claimed knowledge and power - male doctors, and those who did the work - women. These women became known as ancillary workers - from the Latin *ancilla* meaning maid-servant. Many female health workers wore and still wear uniforms which reinforce this status - that of a uniformed maid serving dominant male professionals.

Ehrenreich and English also dispute the claim that male professionals succeeded on the strength of their superior technology. They argue that in fact men clung to superstition and rituals while women represented a more humane, empirical approach to healing:

> "According to these accounts, (male) science more or less automatically replaced (female) superstition - which from then on was called old wives' tales". (Ehrenreich and English 1973 p127).

They argue that the claim that science supported a natural male dominance of healing is erroneous as the crucial battles took place long before the development of modern science. This was a power struggle between the male establishment and women healers. Male claims on science were used as an additional justification for excluding women from the powerful role of the doctor. An emerging profession needs two things - the approval of the ruling class, and theory on which to base its practice. At the turn of the 20th century both became available.

Ehrenreich and English discuss the emergence of the Popular Health Movement in America which challenged the regularisation of medical training and emphasised a self-help and preventative approach to health care. They claim that this failed because of the inherent sexism in American medicine. In the late 19th century the women's movement disassociated itself from the populist health movement, gave up the attack on male medicine and accepted entrance into it on male terms. Thus the takeover of healing by the male profession was complete - women themselves accepted the idea that the male interpretation of health and healing was correct.

> "The Popular Health Movement was not just a movement for more and better health care, but for a radically different kind of health care. It was a substantive challenge to the prevailing medical dogma, practice and theory. Today we tend to confine our critiques to the organisation of medical care, and assume that the scientific substratum of medicine is unassailable." (Ehrenreich and English 1973 p129).

This division of healing into two functions with male curing becoming medicine and female caring becoming nursing led to associated values being attributed to the two

professions. Medicine became seen to be masculine, scientific and based on abstract theory, and nursing was seen as feminine, spiritual and based in intuition. This according to Ehrenreich and English is a false division brought about by the struggle for male superiority through medicine. They argue that before medicine became obsessed with science healing was a combination of all these elements:

> "Healing, in its fullest sense, consists of both curing and caring, doctoring and nursing. The old lay healers of an earlier time combined both functions, and were valued for both."
> (Ehrenreich and English 1973 p131).

Discussion

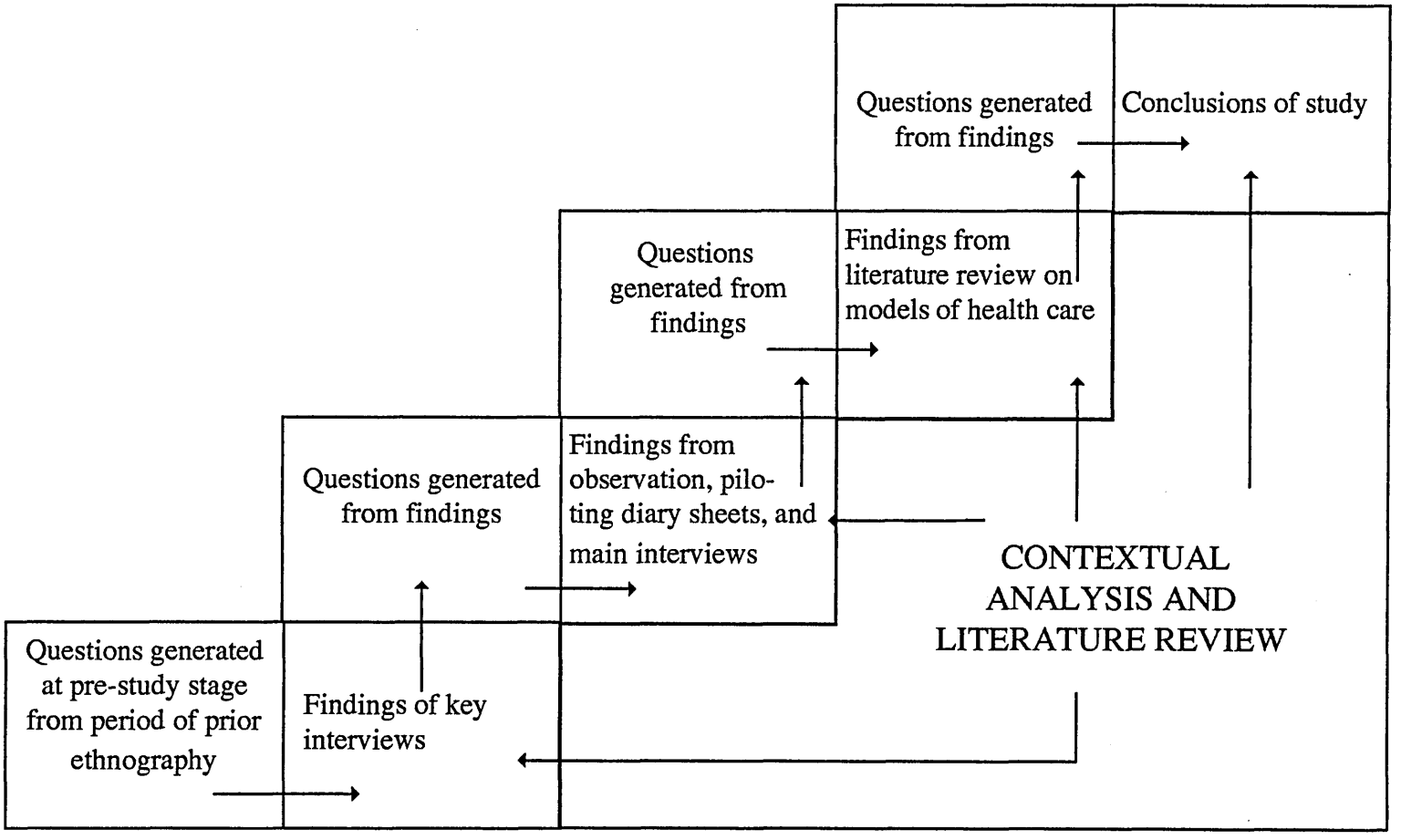
The dominant theme of this section has been the emergence of an organised system of medicine in this country, supposedly based on scientific principles, centralised into hospitals for the convenient pursuit of medical research, and dominated by male professionals in close alliance with the contemporary establishment of Church or State.

The effect of this development on physiotherapy has been complex. As a predominantly female profession some comparison with nursing is valid. Those who claim that physiotherapy developed from nursing would certainly claim that physiotherapy has fought, and lost, the same battles. However, the analogy is not straight forward. Medicine is a male profession based on male values, nursing a female one based on female values. Physiotherapy has attempted, perhaps successfully to have a foot in both camps. As Sim (1985) argues, physiotherapy involves both curing and caring, and therefore lies somewhere between the archetypal male role of the doctor and the female role of the nurse. This may according to Sim allow physiotherapy to establish its own unique sphere of expertise. He claims that physiotherapists are in an ideal position to bring together the rigorous scientific discipline of medicine, and the more humanistic orientation of nursing.

This argument is seductive - it echoes Ehrenreich and English's claim that the two functions of healing - care and cure - should not have been split into medicine and nursing. It offers physiotherapy the chance to claim that it can combine aspects of these two functions and produce healing that is holistic. However, there is little evidence that the physiotherapy profession understands this argument, or is interested in interpreting its practice in this way.

Figure 3

Diagrammatic representation of the relationship between question formulation, use of findings, data collection and literature reviews.



3. METHODOLOGY

This section describes and discusses the methodological issues that arose in designing the study. A review of the literature and consideration of practical and ethical issues arising from the nature of the research undertaken informed the choice of the research methods used. The extent to which decisions taken were informed by the literature is demonstrated along with the breadth and depth of literature studied in the field of research methodology.

This section also demonstrates the emerging nature of the study design and shows how data collection was not limited to one particular phase of the study, but was continuous throughout the whole project (Figure 3). As pertinent issues emerged from data they were incorporated into the next phase of the study. At any one time, the emphasis of the investigation was specific to the setting in which data collection was being undertaken, while being bound by the overall framework of the study.

3.1 Methodology and Personal Perspectives

Morgan and Smircich (1980) claim that a discussion of methodology has to be closely linked with the theoretical issues embedded in the study and argue that a pre-occupation with methods on their own obscures the link between the assumptions of the researcher and the overall research effort. With this in mind it is proposed to demonstrate that the choice of methods was determined by the objectives of the study, these objectives being determined by the research questions, which in turn were determined by a number of other factors including my personal and professional paradigms.

One very significant factor which influenced the methodological framework of the research was its exploratory nature, designed to provide insight into the world of the participants, rather than to discover facts or prove a hypothesis. Silvermann (1993)

described the difference in the nature of the research interview in positivist data collection and interactionism as due to the different purposes for which they are designed:

> "According to positivism, interview data give us access to facts about the world; the primary issue is to generate data which are valid and reliable, independently of the research setting..... According to interactionism, interviewees are viewed as experiencing subjects who actively construct their social worlds; the primary issue is to generate data which give an authentic insight into people's experience...." (Silvermann 1993 p90-91).

Morgan and Smircich (1980) argue that favoured research techniques are often linked to underlying assumptions and that discussions of methodology need to highlight and demonstrate links between theory and method, and between:

> "... the world view to which the researcher subscribes, the type of research question posed, and the technique that is to be adopted as a basis for research." (p499).

They argue that it is therefore necessary for researchers to acknowledge and describe their position in these issues before considering the choice of methods most appropriate to answer their research questions.

Taylor and Bogdan (1984) similarly define methodology as the way in which researchers approach problems and seek answers. They argue that the assumptions, interests, and purposes of the researcher directly influence the choice of methodology and claim that debates about methodology are in fact debates about assumptions, theories and perspectives.

Morgan and Smircich (1980) use the model of a continuum to demonstrate a network of basic assumptions characterizing the subjective-objective debate within social

science. At the subjective end of the continuum lie assumptions that reality is a projection of human imagination, that man is a pure spirit and a conscious being, and that understanding of the world can only be achieved through a phenomenological approach. At the other end they place assumptions that reality is a concrete structure, that man responds to his environment according to pre-determined rules, and that research is done to specify precisely the laws that govern the relationships among measurable phenomena and thus construct a positivist science.

Although they describe six points on the continuum which demonstrate varying assumptions about human nature, Morgan and Smircich (1980) emphasise that the usefulness of such a model is in providing a framework for thinking about the kind of assumptions that underlie research. They note that the transition from one perspective to another must be seen as a gradual one, and that the advocate of a particular stance may well incorporate elements from others.

Cohen and Manion (1985) also emphasise the important influence of the researcher's stance in the nominalist-realist debate and its profound effect on methodology:

> "The view that knowledge is hard, objective and tangible will demand of the researcher an observer role, together with an allegiance to the methods of natural science; to see knowledge as personal, subjective and unique, however, imposes on the researcher an involvement with his subjects and a rejection of the ways of the natural scientist." (Cohen and Manion 1985 p7).

Taylor and Bogdan (1984) describe positivism and phenomenology as the two major theoretical perspectives that have dominated the social science scene. They argue that the positivist is seeking for the facts or causes of social phenomena and consider these to be external to the individual, whereas the phenomenologist examines social phenomena from the perspective of the person experiencing them. They describe the way in which the adoption of different methodologies derives directly from the

different perspectives held by the researcher:

> "Since positivists and phenomenologists take on different kinds of problems and seek different kinds of answers, their research demands different methodologies." (Taylor and Bogdan 1984 p3)

Cohen and Manion (1985) support this argument that the world-view of the researcher will greatly influence the design of the research and the choice of methodology:

> "the choice of problem, the formulation of questions to be answered ... methodological concerns, the kind of data sought and their mode of treatment - all will be influenced by the viewpoint held." (Cohen and Manion 1985 p9).

Cohen and Manion (1985) describe phenomenology as a theoretical viewpoint which sees behaviour being determined by the phenomena of experience rather than by external, objective and physically described reality. This viewpoint regards the study of direct experience as inherently valid.

The same authors describe ethnomethodology as being concerned with how people make sense of their everyday world. They advocate this approach in natural settings such as the classroom and presumably would support its use in health care settings such as wards:

> "A characteristic common to the phenomenological ethnomethodological ... perspectives ... is the way they fit naturally to the kind of concentrated action found in classrooms and schools ... Yet another shared characteristic is the manner in which they are able to preserve the 'integrity' of the situation where they are employed." (Cohen and Manion 1985 p36)

Morgan and Smircich have argued that the world-view of the researcher will greatly influence the design of any research. Cohen and Manion take a similar stance and it is

clear that when other people are involved in either initiating or controlling the research then their world-view must also influence to a greater or lesser degree the formulation of research objectives and method of investigation.

However, in the study undertaken I had control from the outset over what was to be investigated and how the investigation was to be carried out. Having once indicated an area of interest to the funding body I was then free to develop the study without being constrained by vested interests of other parties. There were other constraints which did influence the investigation; these were not implicit in the design of the study, but were external factors such as access to the field and research supervision.

The study is therefore much more of a personal statement than would have been the case if the research were part of a larger project, or if the research questions had been asked and the study initiated by someone else. Under those circumstances the world-view of others would have influenced the design of the study from the beginning. In this case however my own perspective of reality and truth shaped not only the research objectives and the methods by which these objectives were to be fulfilled, but also the original research questions. My place on Morgan and Smircich's subjective-objective continuum determined the type of research question that was posed, the content being determined by my clinical experience and interest.

The perspective of myself as researcher is therefore accepted, for the purposes of this study, as a major influence on each stage of the research process. An understanding and open acknowledgement of this perspective contributes to the overall quality of the study. In this case my own perspective can be described as being towards the subjective end of the continuum, seeing reality as a social construction and recognising phenomological and ethno-methodological contributions to the understanding of human nature. How this has influenced the design of the study will be further demonstrated as this section on methodology concentrates on particular issues of data

collection and interpretation.

3.2 Naturalistic Design

The foundation on which this study is based is my clinical practice as a physiotherapist working in two hospital settings with elderly patients. The study arose directly out of my clinical experience as a practitioner. It was necessary therefore to identify a methodological approach to the research which made use of the experience of the researcher and in which this would enhance the study.

Lincoln and Guba (1980) describe naturalistic inquiry as being built on tacit knowledge which is often labelled as 'merely subjective' and as such is considered inadmissible. But, they argue, this tacit knowledge will be influential whether it is acknowledged or not. Tacit knowledge is defined by Lincoln and Guba (1980) as a set of understandings that cannot be defined, or dealt with in language. They cite Stake (1978) to expand on this definition:

> "Tacit knowledge is all that is remembered somehow, minus that which is remembered in the form of words, symbols, or other rhetorical forms ... Tacit knowledge includes a multitude of inexpressible associations which give rise to new meanings, new ideas, and new applications of the old. ...each person has great stores of tacit knowledge with which to build new understandings." (Stake1978 p196)

Having accepted the existence and importance of this tacit knowledge it was then necessary to find a way of incorporating it to advantage in the study. Lincoln and Guba claim that the naturalistic paradigm makes the use of tacit knowledge both explicit and legitimate. The case is therefore put that when the research is so closely embedded in the experience of the researcher, as in the case of practitioner research, a naturalistic design is the most appropriate choice.

Approaching this from another angle, Lincoln and Guba argue for a period of 'prior ethnography' - a term they ascribe to William Corsaro (1980). This entails becoming a participant observer in a situation for a lengthy period of time before the study is begun. The advantages of this, according to Lincoln and Guba, are so great that they recommend it to all who are seriously interested in doing naturalistic inquiry. Among the advantages of this period of "prior ethnography" are the provision of:

> "...a baseline of cultural accommodation and informational orientation that will be invaluable in increasing both the effectiveness and the efficiency of the formal work. It serves to sensitise and hone the human instrument." (Lincoln and Guba 1980 p251).

In the study being reported here this period of 'prior ethnography' occurred before the actual project was started and relates to my total experience as a clinical physiotherapist. Practitioner research brings, through this tacit knowledge, a whole wealth of background knowledge and experience that can only be acquired by working as that particular professional in that specific area. Having been totally immersed in the culture in which the investigation was grounded, professional terminology is known, and common working practices and routines understood.

The researcher is therefore in a clear position to record what is different and what is usual in her own field of expertise. This can be a clear advantage over the stranger to whom everything may appear unusual. Having good knowledge and experience in the field means that what appears to the practitioner-researcher to be important issues or areas worthy of investigation arise from direct experience. They are therefore more likely to be considered important or relevant by other practitioners and to be of direct relevance to clinical practice.

As the study was so deeply rooted in practice it was seen as unnecessary and indeed impossible for me to adopt a totally new role for the period of the investigation.

Pretending to be a stranger to the field would be difficult, ethically questionable, and could be counter-productive. Any argument over observer bias could be countered by an examination of the nature of the research process and in particular discussions over whether research is ever free of bias. Indeed Marshall (1981) argues that bias adds to the process of enquiry:

> "My bias is something I appreciate, it's part of me as a researcher. And while it is important for me and for others to recognise my bias, it is really what I can give as a researcher....." (Marshall 1981 p337).

The approach which Lincoln and Guba (1980) term 'naturalistic' is called by Parlett and Hamilton (1972) 'illuminative'. They too argue the case for the acknowledgement of the subjective nature of research and claim that behind concerns over whether personal interpretation can be scientific lies:

> "... a basic but erroneous assumption that forms of research exist which are immune to prejudice, experimenter bias and human error." (Parlett and Hamilton 1972 p18)

They advocate the use of precautionary tactics such as the cross-checking of important findings when extensive use is made of qualitative techniques but argue that even with such precautions the subjective element remains and indeed is inevitable.

> "When the investigator abandons the agricultural-botany paradigm his role is necessarily redefined. The use of human insight and skills is, indeed, encouraged rather than discouraged." (Parlett and Hamilton 1972 p22)

These precautionary tactics have been well documented under the term triangulation of methods and are considered by many to be an important aspect of qualitative methodology. As the methods used in this study are qualitative, triangulation of methods was considered and issues relating its use to the study discussed.

3.3 Triangulation

Triangulation is defined by Cohen and Manion (1980) as the use of two or more methods of data collection in the study of human behaviour. They see its use as appropriate because of the complex nature of human behaviour and interaction. Babbie (1983) defines triangulation as the use of several different research methods to test the same findings and argues that this is a valuable research strategy to avoid methodological bias claiming that as each research method has its own particular strengths and weaknesses the use of more that one will help eliminate bias.

This positive view of triangulation is shared by many including Miles and Huberman (1994) who suggest building this into the methodology as part of the process of data generation, collection and analysis:

> "...triangulation is not so much a tactic as a way of life. If you self-consciously set out to collect and double-check findings, using multiple sources and modes of evidence, the verification process will largely be built into data collection as you go." (Miles and Huberman 1994 p267).

Burgess (1982) discusses this issue under the heading of multiple methods of investigations, and examines how they have been used in a variety of studies. He particularly cites anthropological studies that have used several methods to gain access to data, and suggests that one question to be asked is whether different methods have been used to focus upon the same unit of investigation, or to examine different aspects of the same study. Different combinations of methods have been used, but Burgess argues that it is only when observational and interview data are integrated that the full potential of multiple field methods can be realised.

Similarly, Cohen and Manion (1985) discuss different ways of categorising

triangulation and attribute one of these to Denzin (1970) which differentiates between "within methods triangulation" where a study is replicated to confirm reliability, and "between methods triangulation" where different methods are used to collect data on a particular objective. Cohen and Manion argue that this latter approach is particularly appropriate to educational research because of the complex issues involved.

However, Sidell (1993) identifies potential problems with the use of different methods in the same study because of the different philosophies upon which they may be based:

> "Different research methods are not simply different ways of doing, they also represent different ways of seeing and ways of thinking..... Quantitative methods are based broadly on the philosophy of positivism..... Qualitative methods arise from a different philosophical tradition, one which looks for meaning behind social action." (Sidell 1993 p108)

There are clear similarities between the methodological requirements of practitioner research in health care and those of practitioner research in education and the "between methods triangulation" described by Cohen and Manion is equally appropriate to the study being undertaken. However, Sidell's point about the incompatibility of different methods has value but applies to methods which arise from different philosophical viewpoints. I could not justify the combination of qualitative and quantitative methods in this study, but there is a range of qualitative methods available, which share the same philosophical base and it is from these that a selection was made as the fieldwork stage of the study developed and progressed.

3.4 The Emerging Design

Parlett and Hamilton (1972) describe their illuminative approach to evaluation as having three phases: investigators observe, inquire further, and then seek to explain. These three stages overlap and interrelate:

> "Beginning with an extensive data base, the researchers systematically reduce the breadth of their inquiry to give more concentrated attention to the emerging issues. This 'progressive focusing' permits unique and unpredicted phenomena to be given due weight."
> (Parlett and Hamilton 1972 p15)

Lincoln and Guba explain the naturalistic inquiry in three phases also. They call these: an orientation and overview phase, the object of which is to obtain sufficient information to decide what issues are important enough to follow up in detail, a phase of focused exploration when, having analysed data from phase one and developed more structured protocols, in-depth information is obtained. Phase three consists of writing a report on the information received, which is taken back to the site for 'member check'. The purpose of this is to obtain confirmation that the report has captured the data as constructed by the informants or to correct or amend it.

3.5 The Research Process

Phase One

This is the period of prior ethnography which occurred before the project formally began. It matches the phase of observation (Parlett and Hamilton 1972) and overview (Lincoln and Guba 1980) and provided the tacit knowledge described by Lincoln and Guba, which led to the formulation of the particular research questions. It is important for researchers studying their own field of practice to acknowledge the major influence of this preliminary phase as it directly affect methodological decisions made throughout the study, provides a framework and influences the choice both of the research question and the method(s) chosen to investigate it.

One underlying concept or assumption in illuminative evaluation is that a system or individual activities can only be understood if contextualised. Parlett M (1981). Prior ethnography provides that contextualisation. This accords with Fetterman's description of the emic perspective as the starting point for data collection (1991) .

This emic perspective is the insider's or native's perception of reality, and is used to help explain why members of the social group do what they do and contrasts with the etic or outsider's perspective. (Fetterman 1991)

Phase Two

The interviews which were undertaken at the beginning of the project served to focus the study and provide in-depth information from a number of key individuals. Parlett and Hamilton (1972) describe this stage as a time of further inquiry, Lincoln and Guba (1980) as a period of focused exploration in order to gain in-depth information.

This series of interviews was with individuals selected by the researcher because of their intimate knowledge of the field in which the research was to be carried out, because of personal contact, and because they expressed an interest in, and views on, the area of inquiry. The interviews were unstructured and non-directive. This approach arose from therapeutic interviews (Cohen and Manion 1985), the principal features being:

> "...the minimal direction or control exhibited by the interviewer and the freedom the respondent has to express his subjective feelings as freely and as spontaneously as he chooses or is able." (Cohen and Manion 1985 p293).

Moser and Kalton (1977) are cited by these authors to confirm the appropriateness of this type of interview when complex issues are being explored, and when the researcher's knowledge of what is important is still in a vague and unstructured form.

The data collected in these key interviews is presented later. They served to focus the study on key issues that were considered important to people in the field, or to those who had direct influence over them. This period of focusing led to decisions about how to collect data specific to the issues that had been raised. The methods chosen

were direct and indirect observation and in depth interviews.

Observation

In a naturalistic design observation is regarded by many to be one of the most important instruments available to the researcher (Taylor and Bogdan 1984, Cohen and Manion 1985, Patton 1980, Parlett and Hamilton 1977). The term observation however covers a variety of ways of collecting field data. Different authors use different models to discuss observation as a research tool and it is used both by ethnographers to describe their close involvement in a social setting and by laboratory technicians recording experimental data. Gans (1982) observes that :

> "... in sociology the term participant observation refers to a multitude of activities and roles: the term is only a loose and inaccurate label that covers the many varieties of participation and observation, and distinguishes them from formal interviewing or library research."
> (Gans 1982 p54).

In this study observation was used at four stages. Firstly there was the period of observation or prior ethnography before the research project was started. Secondly field notes were made whenever there was contact with the setting, for example when negotiating access and while waiting for interviewees. Thirdly a form of indirect observation was used when people were asked to complete diary sheets. Fourthly the researcher's involvement in professional affairs both locally and nationally generated data that conforms to Douglas' (1976) description of direct experience.

Observation prior to the study

The validity of using data collected prior to embarking on a study has already been discussed under the section on the choice of a naturalistic design. It was seen as appropriate to include the collection of data during the researcher's clinical practice as a physiotherapist in this description of the methods used in the study. This can be seen as conforming to Gans' description of the researcher in a naturalistic enquiry as a total

participant where the field worker is completely involved emotionally in a social situation and only re-adopts the role of researcher after it is over. Gans sees this as a very important part of field research:

> "... the field worker ought to aim for at least some total participation if at all possible so that he learns to see the world as it is seen by the people he studies. (Gans 1982 p54).

Observation secondary to other activities

Records were kept of observations made every time there was contact with a member of the setting being studied. These ranged from records of telephone calls made and received, letters sent and received, and field notes after visits to the setting to negotiate access to the field or to conduct an interview (*see Appendix B for example*). These notes and records form what Babbie (1983) calls a field journal. Babbie describes such a journal as the backbone of field research. He advocates recording both empirical observations - what the researcher knows has happened, and interpretations - what the researcher thinks has happened.

Although periods of observation were not deliberately planned and I did not go to the setting in order to observe what was happening, every opportunity was taken to make field notes on the setting when the researcher was there for other purposes. For instance, if an interviewee had been held up or needed to finish something before being free for the interview, then reassurances were given that the researcher was in no hurry, and a suitable place was found to wait where activities could be observed and these were recorded.

A lot of valuable data was recorded in this way and the usefulness of this form of observation as a research instrument was recognised. However, it was not felt

appropriate to use it as a primary method of data collection in spite of its widespread use in naturalistic enquiries. At an early stage in the research it had been considered in relation to one of the aims of the study. It appeared that it might be possible to use it to record interactions between nurses and physiotherapists in order to describe the inter- disciplinary working relationships of nurses and physiotherapists in two different hospital settings. However, practical difficulties were envisaged. These included knowing where to physically position oneself in order to record the interactions. I knew from professional experience that as well as the pre-arranged meetings to discuss patients' progress, valuable information was shared by professionals during casual encounters in the corridor, over the telephone, in the toilets. It would be possible to miss all those and assume that those interactions actually observed were all that occurred.

Shadowing one of the professionals was considered. This would have entailed spending a shift following a particular individual and recording every time information was passed on to or received from a member of the other profession. However, this was not done for two main reasons. Firstly, it was felt that the presence of a researcher would influence the behaviour of the person being shadowed too much. The spontaneity of informal interaction may well have been lost and artificial situations created to impress me with how much interaction went on between nurses and physiotherapists, or conversely normal opportunities for communication not taken up in order to show how little interaction went on.

Secondly, there were ethical reasons for not observing all that a particular professional did during a shift. In particular, it was felt that as there was no research aim in this study that would be fulfilled by me having access to information about patients and their medical, social and personal condition, it would have been unethical to have heard such details while undertaking observation. Although such information need not have been formally recorded in any way, I would still have been privy to knowledge

which the patient had the right to expect to have been kept confidential to those who needed to know. As patients' rights are under constant threat of violation I did not find it acceptable to acquire information which was of not benefit to the study and the acquisition of which could be seen as an invasion of privacy.

Another ethical issue arose when considering using observation as a major instrument in the study. Jarvie (1982) and Taylor and Bogdan (1984) discuss the problem facing researchers who acquire information that they feel in conscience they should act upon, but in doing so would jeopardise the study. From experience in the clinical field I knew that spending long periods on wards for elderly people as an observer would put me in the position of seeing things happen that I felt were wrong, but was unable to prevent or rectify.

The reality of this was shown on the first occasion I went to the setting to talk to the nursing officer about access to the ward. I was sitting in the ward day room with some elderly patients while waiting for the nursing officer. A female patient entered the day room and an incontinence pad she was wearing fell to the floor. The lady used a zimmer frame for balance and support and was unable to retrieve the pad herself. She was obviously embarrassed by the situation and in danger of falling if she bent over any further in her efforts to pick the pad up from the floor.

I had three choices. One was to pretend I wasn't there - to be the total observer with no participatory role in the setting and see how the situation was dealt with. This was not acceptable as the lady was embarrassed by the situation and could have fallen if no-one intervened. One was to act as a physiotherapist and deal with it as a professional. This would I felt have have compromised my position on the ward as it would have placed me firmly as a physiotherapist in the minds of the staff rather than as a researcher who happened to be a physiotherapist as well, which was the emphasis I was aiming for.

The third option, which was the one adopted, was to take on the role of an ordinary lay member of the public and deal with the situation as a visitor to the ward may have done. I therefore asked the patient her name and went into the corridor and explained the situation to the first person I saw in uniform.

This incident highlighted another potential problem with observation in a clinical setting. Wards are notoriously under-staffed and while it is not known whether this has been studied, it is postulated that nurses rely, with or without acknowledging it, on the presence of other professionals and visitors to safeguard patients. A nurse for instance may feel very worried about leaving a day room full of elderly people unattended for long periods. However she may be able to justify a necessary absence if she knows that visitors, or other professionals, are present.

This seemed to me to be very relevant to the adoption of an observer role. The nurses on the ward would know I was there; they would also know I was a physiotherapist and could presumably therefore be relied on to take appropriate action if something occurred that was potentially dangerous, or if a patient needed something. This would therefore influence their behaviour - for instance they might visit the day room less often on the assumption that the researcher would be fulfilling part of a custodial role.

Indirect Observation

The need to develop a way of observing the contacts the nurses and physiotherapists had over patients, without encroaching on the privacy of the patients arose from the practical and ethical issues discussed above. A means of recording these contacts was needed which overcame these problems.

A recording or diary sheet was devised on which members of each of the two professions would record each instance they had contact with the other profession over patient care. Diaries have been used in a number of health care studies as a way or

recording all activity, or activity at specified times to enable a picture to be built up of the working day or a particular professional. In this instance what was wanted was the type of information an observer would have recorded about each instance of interaction had they been present.

A sheet was therefore devised *(Appendix C)* on which the selected professionals were to be asked to record details of the interaction under specific headings. What the researcher wanted to know was how often nurses and physiotherapists communicated about patients, where and when this took place and whether it was the more formal, pre-arranged meetings that were most valuable, or the informal exchange that occurred casually in the corridor.

The diary sheets were to be given to two people. One would be a nurse directly involved with care of a specified patient. The other would be the physiotherapist involved with the same patient. These two people would be asked to record all contacts they had with each other about a particular patient. The patient was to be chosen by the two professionals jointly. The criteria given by the researcher for selection were that the patient should be one whom on admission was clearly in need of some physiotherapy intervention and therefore communication between the nurse involved in their care and the physiotherapist on the ward would be necessary, and that the patient was expected to be on the ward for a number of weeks. Were the patient to die or be discharged soon after admission then another patient was to be selected for the purpose.

It was emphasised to the two professionals that the researcher did not want to know any details about the patient beforehand. There was no need for their name to be recorded but the researcher would want to know some details about their condition and would therefore be asking some questions once the data collection was complete.
As part of the investigation focused on the knowledge and understanding of both

professions of physiotherapists' role in the management of incontinence and pressure sores the two recorders could have been asked to select a patient with one or both of these conditions. However, it was felt that stating this would have indicated that these were conditions about which the researcher was expecting the two professionals to communicate. As it was important to discover what they themselves thought relevant to the other professional to know, these two conditions were not mentioned. This was not anticipated to be too much of a problem as the prevalence of both pressure sores and incontinence is very high in elderly people in hospital and it was anticipated that the patient chosen may well be suffering from one of the other. In the event that this was not the case it was envisaged that at the follow-up interview questions could be asked about whether the professional would have thought it relevant to discuss these two conditions with their opposite number.

Initially when the diary sheet was first developed it was hoped that it would be used fairly extensively in both settings to generate data about how and when nurses and physiotherapists communicate about their patients. In practice, it was the negotiations about the use of the diary sheets that yielded the most valuable and prolific data, rather than completion of the diary sheets themselves.

Piloting the Diary Sheets

I saw the piloting as a way of discovering the feasibility of using this form of recording in the main study. It was hoped that the two people doing the recording would give plenty of feedback both about the process of filling in the sheets and also as to whether they were a reliable way of recording contacts made.

The diary sheets were piloted at a hospital as similar as possible to those in the main study. This hospital was for elderly people suffering from a range of medical and social conditions which necessitated admission for short or long term care. It had a small physiotherapy department and had the reputation within its health authority of

enjoying good relationships between nursing and paramedical staff.

Both the superintendent physiotherapist and the nursing officer were contacted by the researcher by telephone and an appointment arranged. This first interview was done on an individual basis to explain the purpose of the research, the diary sheets, and the need for piloting. The superintendent physiotherapist worked on the ward and agreed readily to fill in the sheets herself. The nursing officer suggested a particular ward sister as the most appropriate person to fill in the sheets from the nursing side. A time was therefore fixed to talk to the sister.

This sequence of making contact with the professionals highlighted an issue which was significant throughout the negotiations for access. The physiotherapists initially contacted were all the managers of the physiotherapy departments at their hospitals. They were therefore able to agree to their staff being asked to participate in the study. They were, in all cases but one, both the superintendent of the physiotherapy department and a clinician. They not only agreed to the researcher's request for access, but also volunteered to participate personally. On one occasion when it was not feasible for the superintendent to participate herself, it was suggested that the researcher contact another named physiotherapist to see if she was interested in taking part.

The nursing hierarchy was different however. Contact was made both in piloting and in the main study with the nursing officer who was in all cases able to make a decision about access to nursing staff for research purposes. However, these nursing officers were not clinically involved in the wards and therefore would not be actually filling in diary sheets themselves. They therefore designated named members of staff to participate in data collection, and these nurses were told by their nursing officer that they would be taking part in the study.

Attempts were made by me to intervene in this process and ask permission to approach

ward sisters less formally, but with the way nursing management was organised it proved difficult. Certainly none of the nursing officers appeared to acknowledge that there would be any difference in a sister participating in a study because she had been asked to by the researcher personally, or because she had been told to by her manager.

This was a significant factor in the process of data collection particularly in one hospital as will be discussed later. The issue is raised here because it became clear to me during piloting that the nursing officer decided who would be cooperating with the study and this would not be a volunteer as in the case of the physiotherapists involved.

Another important point indicated by the piloting was the time delay in getting data collection through the diary sheets actually started. Initially I left it to the professionals involved to start completing the diary sheets as soon as a suitable patient was admitted to the ward. The superintendent physiotherapist and the ward sister were seen together to explain the use of the diary sheets and details of their completion. They were then seen individually a few days later to answer any queries and to check that they understood what was involved. The folders containing instructions, the blank sheets and stamped addressed envelopes were then left with them so they could start to fill in the sheets.

There followed a long period of delay before any data were collected on the sheets. Both the physiotherapists and the nurse emphasised to me that this was not a typical period in their working routine and if only they could wait until things were normal then much more valuable information would be collected. Every time data collection was delayed a genuine reason was given as to why this was not a good time to start. Some of the reasons given were that one or other of them was off on holiday, on a management course, on an AIDS seminar, at a job interview, that off-duty arrangements for that week meant they would not see each other, or that one of them was on sick leave.

As it would seem important that communication between the two people responsible for the care of a patient should take into account such periods when direct face to face contact was not possible, I was anxious that data collection should start as soon as possible. The physiotherapist and nurse appeared keen to record during a period which they saw as typical of their usual routine. As the weeks progressed however, it became apparent that this 'typical' period might in fact only exist in theory, and that in practice long periods when the physiotherapist and the ward sister were not on duty at the same time were usual rather than untypical. The difficulty then arose of the two professionals wanting recording to occur during an ideal period whilst I wanted recording to occur during a period which reflected the reality of the setting.

The situation was resolved eventually by me emphasising that the main reason for piloting the diary sheets was to test the mechanics of using them, rather than for the data collected. The physiotherapist and nurse agreed to start filling them in on the understanding that I did not think this would reflect a normal view of their interaction and that allowances would be made for the special circumstances of that period.

This delay in data collection was to be repeated in the main study and was a major reason why the diary sheets were only used in one of the settings and were not in themselves a main instrument of data collection. The data that were collected during the piloting and during negotiation over their use in both the main settings were however extremely valuable. If the diary sheets themselves are considered only as a potential instrument to have been used in this study then they could be perceived to have failed in that they did not of themselves generate a lot of data. However, the process of trying to develop them as a research instrument and the reaction to them in the settings was extremely successful as it highlighted several key issues which were taken up in the subsequent interviews.

Stamped addressed envelopes were supplied by me to encourage the participants to

complete the sheets daily and post them back at the end of each day. As each contact would be recorded twice - once by each of the participants - it was hoped that the data could be checked for reliability and that the different perceptions of the professionals as to the purpose and nature of the interactions could be noted for further investigation at the interviews which were to follow the period of completion.

The sheets and envelopes were supplied inside a folder, on the inside of which was glued the instructions for completing the sheets. Each of the two participants was supplied with her own folder. It was envisaged, and this was confirmed during piloting, that the physiotherapist would keep her folder in the physiotherapy department and complete the sheets at the end of the morning or afternoon when she returned to her office. To facilitate this the physiotherapist was supplied with a small notebook to keep in her pocket in which it was suggested she keep rough notes of the contacts she had during the day with the ward sister. The sister kept the folder in her office or at the nurses' station and as she returned there regularly during her shift it was not found necessary for her to have a pocket note-book.

After completing the sheets for two weeks I decided that enough feedback had been received to make a significant contribution to the development of the diary sheets. This physiotherapist was going on annual leave and would then be moving to another post in the district. Given the amount of time that had been spent waiting for data collection to begin it was considered prudent to use the lessons learnt from piloting and move onto the main study.

The feedback from the two participants during piloting was very useful. Apart from the issues noted above, there were very pertinent points made that could only have been highlighted by use of the sheets in practice. The ward sister suggested that a space was included for the nurse to record her working hours on the first sheet completed each day. This would explain to the researcher why certain contacts

occurred at certain times and not at others. For example, the physiotherapist might have to leave a message with a third party because she would not be around when the sister came on duty. It was also suggested that on days when no contact was made a blank but dated sheet was returned so that it was clear that the participants had not just forgotten to complete or post them. Minor alterations were also made to the layout of the sheet and the terminology used after discussions with the participants.

After the two week completion period was up, I went to see both participants to obtain any final feedback and to thank them for their time and cooperation. The one point that both parties emphasised was that they did not feel that what they had recorded on the sheets was an accurate reflection of the communication that actually occurred between them. Neither of them could be more specific about what had not been recorded, or make any suggestions as to how other communication could be recorded. As it had been emphasised throughout that ALL contacts with the other professional should be recorded and that this should include messages left with third parties, written and verbal contacts, and information given to third parties with the assumption that it would eventually get to the other professional, it was difficult to understand what it was they felt had not been adequately shown on the sheets. This issue was noted for further investigation in the main study. *(See Appendices D and E for examples of completed diary sheets and collation of resulting data).*

Observation by participation in professional activities

During the fieldwork phase of the study I was seconded from the employing Health Authority. Contact with the Health Authority and particularly with the district physiotherapy service during this two year period could have been negligible. However, close contact was maintained in order to retain clinical expertise. This was a conscious decision as the research was so closely linked to the professional experience of physiotherapy. The contacts consisted of continuing to participate in the on-call rota and therefore working occasional weekends and evenings, attending

seminars, and meeting with colleagues socially and at work functions.

The maintenance of close contact with staff meant that access to one of the settings was extremely easy to initiate. The disadvantage was that the physiotherapists in that setting emphasised my identity as a physiotherapist whenever I was there. This necessitated working hard to ensure that the nurses on that ward saw me as a researcher first and a physiotherapist second.

On one occasion I was in the ward kitchen chatting to the nurse whom I was about to interview. This nurse was making us both a cup of tea. One of the physiotherapists was passing the kitchen and upon seeing me said that if I had wanted a cup of tea I should have gone into the physiotherapy department and made myself one. This was said in a friendly tone to indicate that I was always welcome and should feel able to use the facilities of the physiotherapy department. However, this emphasised to the listening nurse that I was a physiotherapist and was closely identified with the physiotherapy department in that hospital.

This highlights one of the problems for practitioners of doing research on their own ground. This can be overcome with care and constant attention and in this case was outweighed by the advantages of ease of access and familiarity with the setting. Problems over access in the other setting in which I was not so well known supported this point.

In addition to local involvement I also developed national links within physiotherapy. There is a special interest group for physiotherapists working with elderly people (Association of Chartered Physiotherapists with a Special Interest in Elderly People also known latterly as AGILE) and the researcher took on the honorary position of Research and Information Officer. This is one of the very active special interest groups in physiotherapy and has produced documentation about physiotherapy practice

which has been invaluable in the study.

The researcher was also elected to the Council of the Chartered Society of Physiotherapy. This provided access to data which would not otherwise have been available, and also strengthened the links between theory and practice within the study.

Interviews

This section describes the use of the interview in research and its particular application in this study. After a discussion of some of the different types on interviews that have been identified in the literature on research methodology, a detailed account is given of the pilot interviews conducted by the researcher. This is presented in some detail to demonstrate the practical nature of the methodological development of the interview as a method of data collection appropriate to this research project.

The varied nature of the research interview is highlighted by the many definitions found in the literature (Cannel and Kahn 1968, Burgess 1982, Whyte 1984, Brenner, Brown and Canter 1985, Cohen and Manion 1985, Powney and Watts 1987, Silverman 1993). Burgess (1982) uses the model of a continuum to discuss the different types of research interview which ran from the structured interview commonly used in survey research to the unstructured conversation favoured by some ethnographers. Powney and Watts (1987) suggest that classification of interviews should be done by looking at who is in control of the interview.

Brenner, Brown and Canter (1985) note the considerable complexity of the interview as a social process and its value in a wide diversity of contexts. They claim that it is widely accepted as a research tool in its own right and cite Allport (1942) who argued that if you want to know something about people's activities the best way of finding out is to ask them. They also cite Harre and Secord (1972) in support of the argument that the expertise and experience of a respondent is unique and that the account given of this is scientific data:

> "It is this willingness to treat individuals as the heroes of their own drama, as valuable sources of particular information which is at the base of the resurgence of interest in various interviewing procedures." (Brenner, Brown and Canter 1985 p3).

The data collected in interviews is open to different analytical approaches. Both qualitative and quantitative analysis can be used and the choice will depend on the objectives of the interview. Brenner (1985) chooses to minimise inconsistency and maximise comparisons between informants, whereas Potter and Mulkay (1985) emphasise the possible relevance of "the variability of interpretive repertories" and regard inconsistencies as valuable data.

Mostyn (1985) emphasises the difference between quantitative and qualitative approaches in saying that qualitative research is a learning exercise - an expansion of existing data - rather than a refinement as in quantitative research. Powney and Watts (1987) reinforce this idea when they discuss interviews used by ethnographers not to provide discrete data but to make sense of puzzling information and to enhance insight into a situation. They cite Cockburn (1980) who categorised interviews as sociological or phenomographical. The sociologist stays at a distance from the phenomenon under scrutiny in order to attain some objectivity and the focus lies with the researcher's interests and concerns. Phenomographic interviewers see themselves on the other hand, as tapping into the perceptions of those inside a system in order to be able to work out how it functions.

The use of the interview in practitioner research raises the issue of bias. Powney and Watts (1987) acknowledge the importance of this and its inevitability:

> "Perhaps a 'personal perspective' is a less accusing term than bias but it is inevitable that the interviewer's

> perspective is also limited by knowledge and experience as is the interviewee's." (Powney and Watts 1987 p35).

They identify three possible sources of interviewer bias - the background characteristics of the interviewer, such as age, sex, education, race and socio-economic status, psychological factors such as perception, attitudes, expectations and motives, and behavioural factors related to the conduct of the interview. Cohen and Manion (1985) also address the issue of bias in discussing the use of research interviews:

> "One advantage, for example, is that it allows for greater depth than is the case with other methods of data collection. A disadvantage on the other hand is that it is prone to subjectivity and bias on the part of the interviewer." (Cohen and Manion 1985 p292)

They suggest three different approaches that can be taken over bias. Firstly it can be argued that a good interviewer, adequately trained and with experience, can eliminate bias. Secondly the inevitability of bias is recognised and controlled. Thirdly, it can be accepted that bias is a part of the interview process and it is unrealistic and indeed unnecessary to eliminate it:

> "...(an interview is) an encounter necessarily sharing many of the features of everyday life. ... It is impossible, just as in everyday life, to bring every aspect of the encounter within rational control." (Cohen and Manion 1985 p292).

Powney and Watts (1987) note that the convention has been for the interviewer to be unknown to, or at least not a personal friend of, the interviewee in an attempt to avoid one source of bias. However, they accept the difficulty of this in much research that is going on when interviewer and interviewee may be familiar to each other. Burgess (1982) argues that it is indeed very important for the interviewer/researcher to know about the culture under study so they can share this with their informants:

> "Researchers therefore require a knowledge of technical terms and an ability to ascertain cultural meanings if they are to obtain detail, verify statements, elucidate contradictory data and obtain information that will allow them to evaluate their informants' statements."
> (Burgess 1982 p108)

In defence of this argument they also cite Strauss et al (1964) who maintain that researchers need to become members of the social settings they study if they are to understand their informants.

The relationship of the interview to other methods of data collection is discussed by Burgess (1984) and Powney and Watts (1987) who note that the unstructured interview is rarely conducted in isolation but used to compliment other methods, for instance to clarify points arising from observation.

A particular aspect of interviews is the trust that the respondent places in the interviewer. However, the respondent retains ultimate control of the situation. Powney and Watts discuss the relevance of this in relation to a study of young people who were shown a preliminary report following a period of observation. They are reported as feeling quite alienated from the research:

> "They had no idea that they were revealing so much when they sat talking to a friendly young person in the project premises."
> (Powney and Watts 1987 p27)

The researchers then changed from participant observation to interviews and renewed cooperation was reported from the young people who said they preferred being interviewed to being observed.

The choice of structured or unstructured, informant or respondent interviews is largely determined by the purpose of the interview. Burgess (1982) is quite certain that the standard set of questions of a structured interview schedule is restricting and narrow if

the purpose is to provide opportunity for opening up new dimensions of a problem. Structured interviews define situations in advance and do not allow the researcher to follow up any interesting ideas.

The argument that is identified in the literature as being relevant to the choice of interviews as a method of data collection in this study is whether the researcher, having identified the important issues in advance, wanted factual information to fit into pre-defined categories, or whether this stage of data collection was about expanding understanding of the situation from the perspective of the interviewees. As it was the latter that was most appropriate at this stage in the project, an interview schedule was developed in accordance with this objective.

The choice of the interview as a data collection method has been discussed under a previous section on emerging design. This section has discussed the use of interviews in research and highlighted some of the arguments considered when developing the interviews used in this study. A detailed description is given in the next section of how the theoretical issues identified in the literature were combined with the practical experience of conducting the pilot interviews which resulted in the formulation of an interview designed specifically for this study.

Pilot Interviews

Seven pilot interviews were carried out prior to beginning the main data collection. Three of these were with physiotherapists and four with nurses. The objectives of the pilot interviews were to ascertain whether:

* the format of the interview was appropriate;
* the interviewee was comfortable with both the interview format and the interviewer;
* tape recording was an appropriate was of recording the data;
* the data collected was appropriate to the study objectives;

* there were flaws in the interviewer's technique that needed correcting;

* the interviewer was confident with the mechanics of the interview eg. use of tape recorder.

Samples

I made contact with three physiotherapists I knew. Each of these agreed to be interviewed as part of the pilot exercise. This was felt to be an appropriate method of selecting interviewees as they would know me on the same basis as those to be approached for the main study, and because they had similar experience in working with elderly people.

Volunteers were requested from the district nurse course run locally, one nursing lecturer was asked, and one nursing sister was recommended by one of the physiotherapists interviewed. This selection was sufficiently similar in the important characteristics. Although the amount of experience of the nurses in care of elderly people was not known they had all nursed elderly people during their training or consequently. Most of the nurses were strangers to me as would be the nurses to be interviewed in the main study; two were known but not well - again a situation likely to be repeated in the main study.

All the interviewees were volunteers and were selected on the grounds of availability rather than due to their involvement in a particular setting, but given the objectives of the pilot interviews it was felt that this was appropriate.

Procedure

When the potential interviewee was first approached I explained that volunteers were needed to help pilot interviews for a research project. The physiotherapists and the lecturer knew that I was a physiotherapist, the other nurses did not and this was explained to them. Some of the interviewees understood the term 'pilot interview',

others did not. This term was explained as being a practice run to see if the interviews worked. It was stressed that the information given would not be used in the main study and that one of the main reasons for having these practice interviews was to see if there were any problems that needed sorting out before the main interviews were undertaken. I had drawn up a semi-structured interview schedule consisting of twenty questions with appropriate prompts. This was typed and was in two versions - one for the nurses and one for the physiotherapists - which were very similar.

At the first interview I briefly mentioned the following points before the interview began:

* confidentiality - that anything said would not be discussed with anyone else.

* tape recorder - the interview would be recorded so that it could be typed up in full later if that was acceptable to the interviewee.

* diary sheets - as some of the questions related to the diary sheets, which the pilot interviewees would not have used, these were explained and the interviewee asked to role play and make up suitable answers.

Feedback

The Interviewee's Perspective

The feedback from this first interview was extremely valuable and led to a lot of changes being made in the subsequent pilot interviews and the interviews in the main study. The main feedback concerned the format of the interviews. It was noted that throughout the interview the interviewee asked questions such as:

"Am I answering the question correctly?"

"Is that what you wanted me to say?"

"I'm not sure if that's the right answer."

This appeared to imply that the interviewee felt constricted by the questions from discussing issues that were important to her. She felt that she had to answer correctly rather than by saying what she felt about the issue. Other comments which were made after the interview were that the interviewee had found the interview threatening and uncomfortable:

> "I felt very defensive - why is she asking me all this - doesn't she think I know what I'm doing?"

These acknowledged feelings were supported by body language. The interviewee sat well forward in her chair with her arms folded tightly on the desk and leant over her arms. She appeared tense throughout the interview until at the end the tape recorder was switched off and she sat back and relaxed. She suggested that it would have been useful if she had been sent a list of the questions in advance of the interviews so she had time to think about the answers.

When asked about the tape-recorder the interviewee said she found it off-putting and had been very conscious of it the whole way through the interviews. This had been reinforced by the interviewer who was worried about it not working properly and had checked it several times. thus drawing attention to it. The interviewee also commented that she had found the questions too repetitive and that they jumped from general to specific issues and back again.

The Interviewer's Perspective

Of all the pilot interviews this first was to provide the most learning material about how not to conduct interviews. My main feeling was that the schedule was too restricting. I was conscious that there were a certain number of questions to be addressed and that the interview would not be complete if some of the questions were not asked due to lack of time. On both asking the questions and on listening to the recording later it was clear that not enough time had been allowed for the interviewee

to develop issues that were important to her. Throughout the interview I was aware of the interviewee trying to read the questions upside down on the sheet to see what she was going to be asked next. One of the main points that came from both the interview and the recording was that the interviewee was trying to give text-book answers, or answers that were considered to be correct.

I was nervous about the length of time the interview would take and the tape recorder - whether it was actually recording and whether the recording would be audible. This was translated into tense posture similar to that of the interviewee and nervous laughter at several points in the recording. I also recognised that I had reacted to what had been said in reply to some of the questions. As these were issues on which I had my own views it was easy to let these be expressed by raised eyebrows, questioning glances and comments such as 'oh, really', which were judgemental and could well have affected what the interviewee said in reply to later questions.

The feedback obtained from this first interview was around two main issues - my inexperience as an interviewer and the structure of the schedule. The decision was made to concentrate on improving the first set of problems while retaining the original schedule. Two more interviews were therefore undertaken with some alterations.

Alterations

A longer introduction was prepared which concentrated on issues of confidentiality and stressed that nothing from the interview would be discussed with anyone else. This included anyone else taking part in the study and the interviewee's colleagues or manager. The use of the tape recorder was explained in greater depth as a way of helping the interviewer with note taking, not as a permanent record of what was said. It was acknowledged that most people felt nervous about the tape recorder at first but soon forgot about it.

Control of the interview was mentioned. The interviewee was free not to answer any questions she felt uncomfortable about, was free to stop the interview at any time, and free to refuse permission to record either the whole or any part of the interview. It was also stressed during the introduction that there were not right or wrong answers to the questions and that it was the views and feelings of the interviewee that were important to the research.

I concentrated on not appearing at all judgemental and not letting my own views on issues be at all explicit. The tape recorder was hidden until the issue had been introduced, reassurance given, and permission to record been received. The recorder was not checked once it had been switched on and every effort was made to allow time for the interviewees to develop and expand on their answers and on what was important to them.

The feedback from these two interviews covered several points. The interviewees said that they felt intimidated by the number of questions, were worried about giving the desired information and one said she would have liked a copy of the questions as she was worried she wasn't answering them correctly. This last point echoed the original interviewee.

On the positive side however, they both said that they soon forgot about the tape recorder and did not feel they had been influenced in their replies by knowing it was there. They did not feel the interviewer had been at all judgemental and said they could not tell what her views on specific issues were.

It was felt therefore that the remaining problems with the interviews were that the questions were too restricting and that the format did not allow for issues to be explored. This was mainly because of the number of questions and the concern about getting through them all was not allowing time to clarify or expand issues raised.

It was decided therefore to change the format of the interview and to carry on piloting until I felt I was getting the type of data required by the study. A list of topics was drawn up which would act as an agenda for the interviews. Each of eleven topics was written on a card together with appropriate prompts. Four pilot interviews were carried out with the agenda.

Feedback was requested on the use of the tape recorder, how comfortable or threatening the interview had been, whether there had been sufficient time to say what they wanted to say, and whether they felt they had got anything out of the interviews. All four said they had found it a pleasant and positive experience. Only one was conscious of the tape recorder after the first few minutes and all four said they appreciated the opportunity to talk over issues they felt were important:

> "Made me realise how little I know about nursing."
> "I don't know much about physiotherapy do I?'
> "It has helped me clarify a few things."
> "You never have time to talk things over like this."

I felt much more comfortable with the less structured interview. It was much easier to let the interviewee talk and develop the subject without worrying about getting through all the questions. More subjective information appeared to be coming out of the interviews as subjects were expressing feelings and views rather than trying to give correct answers. This was more appropriate to the study. I also felt able to give more control to the interviewee and let them decide what was important to them about the issue or topic being discussed.

On listening to the recording it was noted that I said far less than in the first interviews and that almost all of the talking was done by the interviewees. It was therefore decided to adopt the agenda style of interviews, to use a tape recorder, to set the scene

by means of the introduction, emphasising issues of confidentiality and control.

The introduction was given verbally by me with key words written on a card as a reminder. This allowed an informal style of presentation with eye contact being maintained to stress that the statements in the introduction were meant and not just being read off pat.

The introduction covered the following points:

* introduction of self as physiotherapist doing some research for the Department of Health at Sheffield City Polytechnic.

* explanation of the research as looking at physiotherapists and nurses working with elderly patients in hospital.

* reason for choice of hospital - because of the special way it has developed its services for elderly people.

* emphasis that it is what you, the interviewee, think and feel about the issues that is important for the study. Other people may think differently, but it is your views that are important.

* recognition that some of the areas are sensitive and some people feel uncomfortable discussing them. You are free to stop the interview at any time or to choose not to answer any of the questions.

* use of the tape-recorder to allow the interviewer to concentrate on what is being said and reassurance that the tape will be wiped clean once transcribed.

* confidentiality - nothing will be discussed with anyone else taking part in the study, nor with your colleagues or manager. Any quotes used in the writing up of the study will not be attributed.

* assurance that although complete anonymity cannot be guaranteed as it is known that you are taking part in the study you will not be identified by the researcher in discussing or writing up the research.

The issue of confidentiality was particularly important as I would be known as a colleague to many of those to be interviewed. In one of the settings it was known that I had close links with the, then, District Physiotherapist. It was emphasised therefore that I was there as a researcher not as a member of the district physiotherapy service.

This proved to be important at the first of the main interviews when on stating that nothing would be discussed with anyone the interviewee said 'not the boss?' meaning the District Physiotherapist. It was important therefore to spend time on the introduction reassuring the interviewees that their confidence would not be broken and that the interviewer was not there on anyone else's behalf.

When interviewing the nurses it was important to explain that I was a physiotherapist. Had a decision been made not to the explicit about this from the beginning it was felt it would have had a detrimental effect on the study. It was unlikely that the nurses would not find out that the researcher was a physiotherapist and may have been suspicious if it had not been discussed.

All the subjects in the pilot interviews were asked if they were conscious that they had been talking to a physiotherapist. The physiotherapists, who all knew me well, said yes but that they felt that this helped as there was a lot of common knowledge that meant things didn't have to be constantly explained. The nurses did not appear from their comments to have been inhibited by knowing that I was a physiotherapist:

> "No, you're not in uniform."
>
> "I don't know you as a physio, I've never worked with you as a physio.
>
> "I know you said you were, but you don't come over as a physio."
>
> "I forgot you were a physio."

One of the main concerns following the first interview was over body language and non-verbal clues given by the researcher. It was particularly difficult not to give feedback in this way when hearing things that were uncomfortable. This was usually criticism of the profession of physiotherapy, or derogatory remarks about physiotherapists. This became easier as time went on and I was almost expecting these remarks.

A lot of effort was put into appearing relaxed and adopting a chatty style of interview. Dress was casual but deliberately not reminiscent of physiotherapy uniform (traditionally navy-blue trousers and a white top). Control was given as far as possible to the interviewee by using their territory, letting them have a clear exit, and arranging the interviews to suit them personally - even when their manager had already said what the best time was. It was felt that the more control the interviewee had over the interview the less likely it was that they would sabotage it.

Conclusion

The interviews can be seen to have served two purposes. One was to collect data that would inform the research process and lead to further work being undertaken; the other was as a tool to develop an understanding of the research process particularly the type of ethnographical research that can be used to examine the interaction of people in a variety of settings.

The extent to which the interviews were successful in achieving these objectives can be determined by an examination of the outcomes of the research undertaken. The data generated was rich and varied and led to the development of a theoretical framework for greater academic analysis of the subject.

The development of my understanding of the research process has been illustrated in this section by the detailed description of the methodological issues that arose and were dealt with during the course of undertaking the interviews. The relationship between the methodological theory in the literature, particularly that related to naturalistic enquiry, and the practicalities of interviewing in real settings, was established as demonstrated here. As such the research process was based on developing a sound knowledge of this type of enquiry and this served the overall purpose of the study well.

4. FIELDWORK FINDINGS

This section reports the findings of the fieldwork. These data are presented in two sections. The first sets out the key issues that arose during a series of unstructured interviews with a range of professionals involved in delivering care to elderly people in hospital. These interviews focused on the relationships between nurses and physiotherapists working with elderly people and how those relationships were seen by the two professions involved and by managers. The second section presents the findings of interviews held with nurses and physiotherapists in the two hospital settings described below.

The purpose of the fieldwork was to generate descriptive data about the practice of physiotherapy from the perspective of physiotherapists themselves and by the nurses with whom they worked. The original question of how much nurses knew and understood about the practice of physiotherapy with elderly people and what it had to offer had at this stage in the research process generated a logically prior question as to how much physiotherapists themselves knew and understood about their own practice. The research process was at this stage focused therefore on those two aspects with interview schedules and observational data collection being constructed in such a way as to generate a wealth of data which would be analysed within a framework constructed both by the themes that emerged from the data and by the location of the researcher in the study.

One of the challenges of using qualitative methodology is the generation, interpretation and presentation of data in a format which conforms to the requirements of academic rigour without losing the depth and breadth of what is not a quantifiable set of findings. The justification for the use of the methodology is elsewhere in this report. This section presents findings which formed the springboard for the development of the final thesis. Qualitative data is notoriously unwieldy and attempts to make it

manageable inevitably lead to anxiety about losing something in the process. The involvement and location of the researcher within the framework means that that which is retained and captured is that which is important to the researcher in the light of the development of the overall thesis. The role of the researcher as the creator of the construct of the thesis necessitates analysis of the data to be undertaken in a reflexive as well as interpretive way. That which is important to the researcher, because it is important to the respondents, is illuminated, that which does not contribute to the framework being constructed is discarded. The rationale for this approach is to be found in the methodology section. It is mentioned here to allow the reading of this part to be within the context of the overall approach of the thesis.

The two settings

The main reason for the choice of the two particular hospitals for the study was evidence that these were two contrasting settings, one in which relationships between nurses and physiotherapists were excellent and one in which these relationships were poor. This was based both on the personal experience of the researcher who had worked in both settings, and on subsequent verbal reports from colleagues. The data collected during the fieldwork confirmed that there were indeed differences in the relationships between nurses and physiotherapists at the two hospitals, but that the significant differences were not those originally observed, and that the reasons why these relationships were different were not those that had originally been the focus of the study.

4.1 Observations from Stage 1 Interviews

This section sets out the key issues that arose during discussions with professionals involved in delivering care to elderly people in hospital. The discussions took the form of a series of unstructured interviews with senior nurses, physiotherapy and nurse

managers, and general managers, all known to the interviewer. The findings are presented here under the main topics that emerged during these interviews.

Care of Elderly People

The term 'care' in the context of elderly people was seen by physiotherapists as meaning different things to them and to nurses. The physiotherapists said they understood care, in terms of their own work, as a functional rehabilitative approach to patients. They saw nursing care as promoting dependency and nurses as having a different understanding of the role of the professional carer. Nursing care was seen by these physiotherapists in terms of *"nurturing", "encouraging dependency", "looking after"*, with patients playing a passive role and nurses an active role.

Physiotherapy care on the other hand was described by physiotherapists as *"encouraging independence" "rehabilitative" "standing back" "allowing the patient to do things" "making life a challenge for the patient"*. The patient was said to be an active participant in care with the physiotherapists taking an increasingly passive role as rehabilitation progressed.

Nurses described care as differing with the dependency level of the patient and the setting in which the care was given. They saw care-givers as needing specific skills in relation to the elderly, especially a respect and liking for the old. One nurse expressed care in terms of helping patients to do things they could no longer do for themselves for instance in relation to bodily functions. Nurses did not express views on differences in concepts of care being held by different professions. One nurse felt that interpretation of care differed with the setting rather than with the professional. She said that some wards were more rehabilitation orientated than others and that this was due to the sister or charge-nurse on that ward.

The idea of care in terms of what the patient wants out of their daily life was expressed

by both professions. One nurse saw it as:

> "helping people to maintain or develop a normal life pattern - normal for them - normal for their life-style - within realistic goals."

A physiotherapist expressed it as:

> "looking at life in terms of the patient's values - what they want to be able to do in their daily life, what they need to be able to do to achieve this and what physiotherapy intervention can help."

Questions which arose out of this issue of care included whether the differences and similarities in defining the concept are based on professional socialisation or individual experience; whether they are dependent on the setting in which the care is delivered; whether people conform to the concept held by key people in the setting; whether people with a similar concept of care are attracted to a compatible setting.

The main reason for discussing the concept of care was to question whether it mattered to the patient if the different professions involved in the delivery of care held different views of what it was they were doing. The nurses did not seem to feel there was a conflict, the physiotherapists said there was and that patients suffered because of it.

Physiotherapy in the Care of Elderly People - Physiotherapists' Views

Physiotherapists working with elderly people expressed consistent views that the key areas of physiotherapy intervention were:

* Stroke rehabilitation
* Other neurological problems particularly Parkinson's disease.
* Dermatology - pressure sores, venous ulcers

* Bandaging - Bisgaard, stump, subluxed shoulders.

* Orthopaedics - post-fracture mobilisation.

* Mobility - anything and everything associated with problems of.

* Agility and dexterity - particularly associated with arthritic problems.

* Positioning - in bed and chairs to prevent complications of immobility such as contractures, pressure sores, chest infections.

* Chest care - acute and chronic lung pathologies.

* Lower limb oedema - prevention and treatment.

* Pain - particularly related to musculo-skeletal disorders.

* Access - to toilets, on and off bed, in and out of chair.

* Dressing - when lack of Occupational Therapy input.

* Frozen shoulders.

* Anxiety.

* Multiple pathology - the elderly as a specific care group.

* Observation of the effect of drugs and side-effects.

Continence

When asked about their contribution to the promotion of continence, the general view was that this meant the treatment of stress incontinence by pelvic floor exercises and interferential therapy. There were several physiotherapists doing specific work in this field with elderly patients as well as with younger people, but this tended to be in an out-patient setting.

A physiotherapist working on a ward for elderly people described the task of 'taking the patient to the toilet' as a chance to do functional rehabilitation. She saw it as so much a part of what physiotherapists did that she did not single it out as continence promotion. Mobility, getting in and out of a chair, balancing, turning, dressing skills were all things physiotherapists were trying to achieve with patients and the act of

taking a patient to the toilet provided an opportunity for practising these skills. Improving the functional level of these skills was seen as the reason for taking someone to the toilet rather than the acquisition of these skills helping promote continence.

In contrast, one physiotherapist said that she never took patients to the toilet because once she started the nurses would expect her to do it all the time and that was all she would be doing. The opposite view was put by another physiotherapist who said that a good physiotherapist on a geriatric ward should spend most of their time "either on the way to the toilet, in the toilet, or on her way out - with a patient hopefully!" Other physiotherapists expressed the view that if they were with a patient who asked to go to the toilet then they would take them and use the opportunity for rehabilitative treatment. One physiotherapist said that having thought about it, an awful lot of what she did was relevant to helping patients maintain or regain continence but she thought of it in terms of other functional activities rather than as continence promotion.

A view expressed by several physiotherapists was that a large amount of the incontinence seen on the wards was not true incontinence but existed because the patient was denied the opportunity or help to get to the toilet. Either physical help was missing, the nurses were too busy, or the environment was wrong; there was poor access to toilets, confusing ward layouts, or *"the system was loaded"* against maintaining continence.

Pressure Sores

All the physiotherapists interviewed said that physiotherapy had a definite input into the prevention and treatment of venous ulcers and pressure sores. In some settings this caused no conflict with nursing staff, but in others it was a highly charged issue with *"battle lines being drawn"*.

When physiotherapists were asked why they felt this was an area in which they should be involved, those interviewed said that they had specific skills which would benefit patients. They had, through their training, a good knowledge of the structure of the skin, the possible effects of trauma, pressure, oedema, lack of sensation, and decreased sensitivity. One physiotherapist said that physiotherapists are trained to observe and re-assess and can use these skills in this area. They also had specific treatments to offer patients such as ultra-violet radiation, megapulse, flowtron, exercises - local and general - ultrasound, local massage, blue-line bandaging.

One physiotherapist commented that physiotherapy was seen as a last resort in this area and therefore not used effectively by doctors and nurses. Another worked in a setting where for at least fifteen years nurses and doctors had regularly referred patients with pressure sores to the physiotherapy department. It was the physiotherapists who were trying out new types of dressings and who regularly did the dressings following physiotherapy treatment. They felt they were doing this as they were more knowledgeable about dressings than the nursing staff and also because it was easier to do the dressing immediately following the physiotherapy treatment. Having to arrange for a nurse to be available to do the dressing was seen as a potential source of conflict *"it's easier just to get on and do the dressing yourself, it helps the nurses out and anyway we're probably better at it."*

Other Key Areas

A common view expressed by the physiotherapists who had chosen to specialise in the care of elderly people was that this was an area in which highly skilled physiotherapists were essential. They had to have a sound knowledge of several areas which are considered as physiotherapy specialities in their own right. These included neurology, chest care, orthopaedics, as well as the problems associated with multiple pathology and the effects of ageing. This knowledge had to be regularly updated and an example of this was given as the 1986 Annual Conference of the Association of

Chartered Physiotherapists with a Special Interest in Elderly People (ACPSIEP) where speakers included physiotherapists who were considered to be specialists in neurology, orthopaedics and chest care in acute settings rather than in the care of elderly people.

Teaching other staff and carers was seen as a legitimate activity by all the physiotherapists interviewed. They saw physiotherapists as having special knowledge and skills which would help other staff do their own jobs more effectively and would help provide continuity of care to the patient.

The areas in which physiotherapists were involved in teaching, either formally or informally, related mainly to lifting and transferring techniques, handling and positioning patients - particularly stroke patients, the correct use of walking aids, and ways to support patients when walking. The staff who were the recipients of this teaching included qualified nurses, student nurses, nursing auxiliaries, domestic staff and porters.

The question was raised during the interviews of whether physiotherapists should 'hand over' more of their skills to nurses. Some nurses took the view that as they were the profession that provided 24 hour care, 365 days a year, they should be the ones who did rehabilitation, rather than a profession that works nine to five, Monday to Friday.

While welcoming the acceptance of the idea that rehabilitation is a 24 hour a day process rather than something that happens in the physiotherapy department, the physiotherapists interviewed were wary of handing over their specialist skills to nurses. In certain areas, such as lifting and handling, they felt it was essential for nurses to know to to carry out correct techniques. They felt however that in general these areas were adequately covered with most hospitals having formal input by physiotherapists into nurse training.

As far as other areas were concerned, it was felt that nurses did not have the theoretical background to enable them to do those rehabilitative techniques that were physiotherapy. If nurses were taught certain procedures they would become technicians in carrying them out rather than skilled professionals, and such procedures may well be incorrectly or inappropriately applied.

Where staffing levels were good, the view was generally held that physiotherapy should be left to physiotherapists, and nurses should stick to nursing. However, where the physiotherapy establishment was very low, there was more readiness on the part of the physiotherapists to ensure that someone carried out treatments when they were not there. On these wards nurses were taught postural drainage, clapping and vibration techniques, and also how to use the vapazone machine to treat pressure sores. These procedures were taught in relation to specific patients and use made of visual aids such as charts on the locker or bed, to ensure that only safe and appropriate procedures were applied to that patient. This was described by one physiotherapist as the physiotherapists prescribing the care, teaching the nurses the necessary skills and then leaving the nurses to carry out the treatment when the physiotherapist was not available. This reflected the view expressed by those physiotherapists reluctant to teach nurses physiotherapy skills that by doing so they would be turning nurses into technicians. The concern that incorrect or inappropriate procedures would be used could be countered by adequate teaching, liaison and checking by the physiotherapist.

Nurses' Views

The views of the nurses interviewed of what physiotherapy was and what it had to offer the elderly patient were very limited compared to those of the physiotherapists. They appeared to reflect personal experiences of the nurses rather than any formal teaching they had received on the role of other professionals.

One senior nurse with wide experience of working in a variety of settings had until

very recently only seen physiotherapists *"teaching leg exercises, coughing and spitting"*. She therefore only thought of physiotherapy in those terms. Other views of what physiotherapists did included *"orthopaedics" "physiotherapists walk people" "physiotherapists are the ones who mobilise people post-operatively or post trauma"*.

When the question of other interventions was raised, such as pressure sore management or promotion of continence, the consensus was that this was not physiotherapy except when nurses had had personal experience of seeing physiotherapists involved in those areas.

> "Pressure sores are nursing business, nothing to do with physiotherapists. Nurses are quite capable of treating them."
>
> "Ulcers and pressure sores are treated by the dermatologist and nurses. There's no need for physiotherapists. They would have nothing to offer."
>
> "... never thought of physiotherapists being involved in continence promotion."
>
> "What has physiotherapy got to do with incontinence?"

One nurse who had worked closely with physiotherapists said that as a nurse her concern was for the patient. As long as the patient benefited it didn't matter who did what. She considered pressure sores to be: *"so awful that it doesn't matter who is involved in their treatment so long as they heal"*. This attitude was interpreted in two ways by other nurses. One saw it as a *"very mature approach"*. Others saw it as a betrayal of nursing and one said that any nurse that felt she needed a physiotherapist to help her must be *"a very poor nurse indeed"*.

The attitude of nurses to physiotherapists as people rather than to physiotherapy as a profession was again based on personal experience, and on the whole was negative. One nurse said her attitude had been formed very early on during her training. As a

student nurse she was aware of physiotherapists being on the ward but never communicated with them. She had no idea how they were organised or how they *"got their patients"*. She saw them as a nuisance because *"they always arrived on the ward when all the real work was done and untidied everything"*. Even though she now saw physiotherapists as having a valid role and said she understood more of what they did, she felt that her attitude had not changed and she still resented physiotherapists on the ward. This same nurse commented that student nurses had more contact and better relations with junior medical staff than physiotherapists. They laughed and joked with doctors, but never spoke to physiotherapists. There was apparently no social contact with them either. Two nurses who had worked closely with physiotherapists saw them as part of the ward team. One said that physiotherapists were *"part of the ward team that planned care"*. The other said she saw the physiotherapist on her ward as *"someone who can offer different skills to the team, someone else to call on"*. A different view was expressed by one experienced nurse who said that she had only ever once seen a physiotherapist on a ward round and it had struck her that this was the first and only time she had seen a physiotherapist contributing to planning care for a patient. This was to her so unusual that it had stuck in her mind.

One nurse spoke of the very poor relations between nurses and physiotherapists and for the need to improve the situation. She said that physiotherapists were *"taught that they were better than anyone else and weren't afraid to say so."* She said that physiotherapists were very derogatory about nurses and their role and skills. As they were very vocal about how they felt, nurses' opinions of physiotherapists deteriorated. This was echoed by another nurse who said that relationships would not improve *"until physiotherapists started treating nurses as equals"*.

The view that physiotherapists were *"out of touch with real life"* was expressed in two contexts. One nurse spoke of the way physiotherapists (and occupational therapists) got patients to do things in totally unrealistic settings in hospital rather than in the

patient's own home. She felt this was a complete waste of time and indicated that her whole view of the remedial professions was based on this concept of their lack of awareness of the real world. The other way in which physiotherapists were seen to be out of touch with reality was expressed when a nurse offered to describe a typical physiotherapist. She said they were:

> "female, middle-class, nice, completely unaware of poverty, social deprivation or different life-styles, totally unable to communicate with patients, very confident."

In relation to this last point, she queried whether there was anything behind this air of confidence. She suspected that it was taught along with massage and was ill-founded.

Physiotherapists were seen as being very directive in their approach to patients. One nurse described them as bullying patients. Another said that physiotherapists had to be directive in order to get results. They had to get patients to do things whereas nurses did not.

One nurse involved in pre and post registration teaching said that physiotherapists were a lot more knowledgeable than nurses in certain areas, but probably didn't realise how little nurses were taught in their basic training. This could lead to resentment by the nurses and be interpreted as physiotherapists being superior and stuck up.

Another nurse in post-graduate teaching had recently been closely involved with physiotherapists in running courses both for nurses and for physiotherapists. She said her growing awareness of what physiotherapy involved was due to personal contact with physiotherapists who were interested in certain areas. Her respect for these individuals had raised her level of understanding of their profession.

Interviews with nurses over how they felt about physiotherapists were very easy to initiate. Even when nurses had little experience of working with physiotherapists or little knowledge of what they did was they expressed very strong views about what they thought of physiotherapists. No-one appeared reluctant to voice their opinions, often at great length and with great feeling.

One incident occurred when the interviewer was introduced as a physiotherapist to a nursing officer who walked into the office by chance. This informal introduction immediately provoked lengthy and derogatory comments on what the nursing officer felt about therapists in general. It appeared that most of the nurses interviewed held strong views about physiotherapists and were only waiting for the opportunity to voice them.

Nursing and Care of Elderly People

Physiotherapists' Views

The physiotherapists working with elderly people had all had experience of working in other settings. Their view of nurses was specific to the setting in which they were working. Generally they had low opinions of the skills of the nurses working with the elderly. However, when asked if these views applied to all nurses they said no - many nurses in other specialities such as intensive care, paediatrics, obstetrics, were highly skilled. It was felt that these nurses had chosen to specialise and had probably done further training. Nurses working with the elderly on the other hand, were seen to be there because *"it's a job"* , *"it's convenient"*, *"the jobs are there"* , rather than from a positive choice. The following views should therefore be seen as being applicable only to those nurses working with the elderly in the settings in which the views of the physiotherapists were sought, rather than generalisations about all nurses.

Physiotherapists saw themselves as being much more highly skilled than nurses. All

agreed that skilled nurses were not generally attracted to geriatric nursing. Two said that physiotherapists were brighter than nurses, and that this was resented by nurses. One physiotherapist pointed out that there was a wide range of academic ability coming into nursing with some nurses having no O-levels while some had degrees, in contrast to physiotherapy students who all had A-levels.

Physiotherapy training was regarded as better than nurse training. Nurses were considered to be less equipped to observe, assess, re-assess and communicate. One physiotherapist expressed this as nurses' inability or unwillingness to *"pick things up from the patient and take them on board"*. It was felt that nurses were reluctant to do things that were not part of their job, whereas physiotherapists would follow things through and see that something was done about an issue that was worrying a patient.

Physiotherapists said that they were used to working on their own, taking responsibility and making decisions. Nurses on the other hand were seen as being unwilling to make decisions or take responsibility in case they were stepping out of line. This was seen to be due to their training and the hierarchical structure in which they worked. Nurses were described as task-orientated rather than patient-orientated. Even where primary nursing was being used as a nursing model physiotherapists felt that the actual delivery of care - often by unskilled nursing auxiliaries - was poor. They felt that nurses were rushing around getting things done rather than spending time with the patients. They appreciated the amount of work the nurses had to get through and accepted that most nurses were basically caring, but felt standards of care were low. Nurses were described as harassed, caring but poorly trained for the job, and resistant to change. One physiotherapist said she felt few of the nurses were working with elderly people out of choice but because: *"it's on their bus route, there are jobs available and to a certain extent they can choose their hours"*.

On one ward where much intense rehabilitation work was done and there was therefore a lot of physiotherapy and occupational therapy input the physiotherapist quoted nurses as saying they disliked working on the ward because *"there's no nursing here" ,"it's not what I trained to do" , "the patients aren't sick - they don't need nurses".* The physiotherapist interpreted these remarks as being indicative of the incompatibility of nurses and rehabilitation.

The two professions involved in these interviews do not appear to have a high regard for each other, either as professions or as individuals. Both sides held strong views about the other's inadequacies and were very vocal about them. The interviewer was know to all those interviewed to be a physiotherapist and that may have influenced what was said - although it did not appear to have tempered what nurses reported they felt about physiotherapists.

Professional Boundaries

The issue of professional boundaries and overlapping areas of intervention emerged from the interviews as being very clearly tied up in the minds of nurses with the development of nursing as a profession.

A lot of the nurses interviewed saw nurses as having to either *"hang on to certain areas" or even "grab back those skills we have given away".* There was a growing awareness of the need to establish certain skills that were true nursing skills and develop areas in which nursing was paramount. Conflict arose in the nurses' experience when physiotherapists claimed expertise in those areas. Only one nurse said she welcomed physiotherapy intervention in treatment, as collaboration between the two professions could only benefit the patient. In contrast to this, one nurse said that she had been severely reprimanded by her ward sister for asking advice from a physiotherapist. She said she had been told that if she was unsure about what to do she should look in the procedure book or ask another nurse. She was told: *"never ask*

a physiotherapist - it makes us look as if we don't know".

On the question of whether nursing was a profession, various views were aired. One nurse said it was developing into a profession but still had a long way to go. Nurses had been seen as subservient to doctors, their handmaidens, for so long that it would take time to change perceptions. Nurses were busy identifying nursing as oppose to medical priorities and trying to establish a professional base. She saw conflict as inevitable because physiotherapists were seen as a threat to nurses in those areas that nurses were trying to establish for themselves.

Another nurse said poor relationships were inevitable because nurses were re-defining their role. Specifically, nurses were taking on the concept of patient advocacy. She said physiotherapists were also extending their roles - she felt into non-relevant fields. However she said that as she had little concept of what physiotherapy actually was she shouldn't judge this. Roles were overlapping more and more, lots of changes were occurring, new ideas were developing and this was bound to lead to conflict. She said that physiotherapists were very critical of nurses and not very tactful. The criticism was what was remembered at the end of the day. In her view, personalities had a lot to do with it. On the question of nursing as a profession, one view expressed was that nursing should not strive to become a true profession:

> "The true professional such as a doctor, puts himself first and the patient second. Nurses would lose something if they became thrusting and dynamic. We would be putting ourselves first."

However, this nurse felt that on true nursing issues the nurse must put the patient's interests first and this may mean entering into conflict with the doctor. She saw the nurse as having a clear role as the patient's advocate.

Physiotherapists saw themselves as having a lot more professional autonomy than

nurses and therefore being much closer to achieving true professional status. They felt this was resented by nurses, particularly physiotherapists' readiness to question the management of a patient. Physiotherapists were often seen by nurses as acting out of turn if they queried a doctor's orders or spoke up on a ward round. Physiotherapists however saw this as good physiotherapy and said it was part of their job not to accept everything the doctor said.

One physiotherapist said that physiotherapy was definitely a profession, but nursing was not. This was because;

> " ..... nurses don't act like professionals. They lack awareness of patient dignity. They lack foresight."

This was, on questioning, narrowed down to nurses in a particular setting, but had coloured this physiotherapist's perception of nursing generally.

Primary Nursing

The issue of primary nursing was raised as a potential source of conflict by two nurses. One nurse saw primary nursing as the way forward in developing nursing status, particularly in geriatric nursing. She described it as giving control over prescribing care totally to the nurse who could therefore decide whether and when to call in physiotherapists and occupational therapists.

One physiotherapist saw the attempt by nurses to gain status through primary nursing as a reaction to their loss of status under the new management structures in that health authority. She said that in another health authority where nurses had high status and sat on senior management teams they did not feel threatened by other professionals and therefore there was less conflict.

A general manager closely involved in the issues arising out of primary nursing

explained the conflict as originating in a misconception of primary nursing. Primary nursing was, in her view, a way of organising nursing care, but did not give nurses any say in prescribing non-nursing care. She saw the roles of key worker and primary nurse as very different. The primary nurse was responsible for ordering nursing care. The key worker was responsible for co-ordinating total patient care. Unfortunately she felt that the two roles had become merged in nurses' minds and this had led to conflict. She said that for the system to work to the patients' benefit a lot of hard work, confidence and maturity was needed.

"We need very grown-up nurses and physiotherapists."

4.2 Observations from Stage 2 interviews.

What nurses think physiotherapists do

There were three areas of intervention which all the nurses interviewed mentioned when asked what physiotherapists working with elderly people in hospital did. One of these, and usually the first to be mentioned, was that physiotherapists had an input into mobility. The second area was teaching handling and lifting, and the third was rehabilitation.

Improve Mobility

Improving mobility appeared to be the area of physiotherapy most valued by nurses. The nurses discussed mobility in terms of improving or maintaining a patient's ability to walk, to get in and out of a bed, and in and out of a chair. They commonly linked this with specific conditions such as stroke or arthritis. Several also mentioned mobility as a means of preventing pressure sores and leg ulcers. As mentioned in the section on incontinence, two nurses linked mobility with continence and valued the potential contribution of physiotherapy to the prevention or treatment of incontinence, although they mentioned that the physiotherapists did not appear to give this priority over other treatments.

Handling and lifting

The teaching of handling and lifting skills was also mentioned by all the nurses as a valuable part of physiotherapy. They spoke about their own need as carers to know the best way to lift patients and avoid back or neck injuries. Some of them also mentioned the benefit to the patients of being lifted and handled correctly. For instance they recognised the problems of dragging a patient up the bed and causing damage to the skin.

The handling and lifting training that the nurses had received from physiotherapists had taken two forms. All of them had at some stage been on a course where there had been input from physiotherapists on handling and lifting. Many of them had also received advice on how to lift particular patients on the ward. This had usually been the result of the nurse approaching the physiotherapists and asking for advice. Only one nurse had ever been rebuffed by a physiotherapist and this was interpreted more as a personality problem with that particular individual rather than as an inappropriate request by the nurse.

Rehabilitation

The third area mentioned by all the nurses when discussing physiotherapy was rehabilitation. The nurses found it very difficult to be specific about what they meant by rehabilitation. Some of them linked it with getting the patients independent, being able to return home, or getting them moving again. However, they had difficulty verbalising just what physiotherapists did to achieve rehabilitation.

Most of the nurses mentioned the treatment of pressure sores as part of what physiotherapists did. Their knowledge about what was involved in this treatment is reported in the section on pressure sores.

What physiotherapists think physiotherapists do

The physiotherapists interviewed at this stage of the study were less clear about what they actually did than were the nurses with whom they worked. They all mentioned improving patients' mobility and increasing their independence, but were reluctant, or unable, to expand on how they actually did these things.

One of the physiotherapists at Hospital W described two approaches to physiotherapy with elderly people. One was group activities - what she described as playing games. The other was what she said she did herself which was treating elderly patients like any other patients. She said she tried to make the treatments more geared to the functional requirements of the person, but otherwise physiotherapy with elderly people was the same as any physiotherapy.

Other physiotherapists mentioned maximising the potential of the individual, making the best of whatever abilities the person had, trying to get the person back to a similar life-style. When questioned more closely about how they achieved these objectives the physiotherapists were again unable or unwilling to be specific about what they did. The most junior physiotherapist interviewed, who had only been qualified a few weeks, was the most specific about what she spent her time doing. She listed her work as chest care, particularly with the onset of winter, mobilising patients and getting them to walk, encouraging patients to do things for themselves, communicating with patients because physiotherapists had more time than the nurses, advising nurses on lifting and handling, particularly stroke patients, treating pressure sores and leg ulcers, and caring for the whole person.

When asked what aspects of their job could not be done by other members of the rehabilitation team, the physiotherapists had difficulty in listing any. They distinguished between those things they would do better than other members but could still be done, such as lifting, mobilising, pressure area care, and a very limited area

which no-one else could do - electrotherapy. They explained that legally no-one else was insured to carry out electrical treatments such as infra-red radiation and therefore that was something that could be clearly identified as physiotherapy. Most of the rest of their work was described as a grey area, or areas of overlap in which other disciplines had input and they as physiotherapists could not claim to be the only experts.

Physiotherapy and Incontinence

Nurses' Views

Most of the nurses interviewed mentioned physiotherapy input in the prevention and treatment of stress incontinence, but their depth of knowledge varied. Most mentioned pelvic floor exercises either by name or by description as a way of preventing the leakage of urine when coughing or jumping. Some of the nurses also knew there were electrical treatments available to physiotherapists, and related these to the prevention and treatment of stress incontinence. One nurse had personal experience of interferential therapy as she had been referred by a gynaecologist to a physiotherapy department for the treatment of stress incontinence. She could not name the modality as interferential but gave an accurate description of the machine and its effect. She claimed it had worked in her case, but could not see any application for this intervention by a physiotherapist on wards for elderly people.

One nursing auxiliary said that there was nothing physical that could be done for incontinence. It was up to the patients themselves whether they wanted to be continent or not. She said that motivation was more important than physical treatment.

The two most senior and experienced nurses at Hospital W showed a greater knowledge of possible physiotherapy interventions in incontinence than any of the other nurses. As well as knowing about pelvic floor exercises and at least one electrical modality, they both discussed at length physiotherapy input into mobility and

the physical ability of the patient to maintain continence which they saw as a highly complex skill. One of these nurses had attended a locally organised continence course which had given this nurse greater insight into aspects of physiotherapy intervention other than for stress incontinence.

The other nurse had shown an interest in incontinence when working with a physiotherapist in a previous post and had acquired a lot of knowledge about the physiotherapy treatment of different types of incontinence. This included an awareness of the role of physiotherapy in increasing and maintaining mobility and in helping the patient to physically manage all the procedures involved in going to the toilet, such as maintaining balance while coping with clothing. These two nurses were very keen to see the physiotherapists at this hospital more involved in continence promotion and regretted the lack of input from the physiotherapists which they explained in terms of lack of time rather than lack of interest.

Physiotherapists' Views

All the physiotherapists interviewed expressed the view that physiotherapy had a role to play in the prevention and treatment of stress incontinence. They all stated that physiotherapists were the experts in teaching pelvic floor exercises - either directly to patients or through a nurse or midwife. None of them however related this to an older age group. They all associated stress incontinence and its prevention and treatment with young and middle-aged women rather than with elderly women.

All the physiotherapists mentioned the use of two modalities of electrical treatment for stress incontinence - interferential and vaginal faradism. Many of them had used interferential therapy in previous posts with a younger age group. Those who had used it with older women said it was more appropriate than either vaginal faradism or pelvic floor exercises as these were specifically used for the treatment of stress incontinence. However, none of them could explain what effect they were trying to

achieve by using interferential, or what type of incontinence they were treating if it were not stress incontinence. They had picked up, either from the literature or from discussions with colleagues that there was a place for interferential in the treatment of other sorts of incontinence, but were unclear how or why it should work. They seemed prepared to used it on a 'try it and see' basis rather than because they had any great commitment to it as a treatment for incontinence.

Two of the physiotherapists mentioned the part their input into increasing mobility played in maintaining continence. They both mentioned this in passing as being so obvious as hardly to need including. Only when encouraged did they expand on how they saw a physiotherapist's input into general mobility and agility as affecting continence. They did not see this role in the same way as the specific treatment available for stress incontinence. Increasing mobility was very much a part of their total work and they did not relate it particularly to continence promotion, but rather to general functional ability.

Physiotherapy and Pressure Sores

Nurses' Views

Most of the nurses were aware that physiotherapists used electrical machines to help in the healing of pressure sores. Their knowledge of what these machines were or what they did was variable. Some knew little more than that the physiotherapist came onto the ward with a machine and used it on pressure sores. Some could name one or two modalities. In Hospital W these were Megapulse and Ultra-violet radiation; in hospital N Vapazone and Ultra-violet radiation. None of the nurses knew what these machines did.

Several of the nurses mentioned the role physiotherapists played in maintaining mobility to prevent pressure sores. One mentioned encouraging paraplegic patients to lift themselves regularly in the wheelchair to prevent sores developing; another

explained the importance of correct handling and lifting of patients to avoid friction on a patient's skin when they were being lifted up the bed. It was seen by this nurse as appropriate for the physiotherapist to teach nurses how to lift patients correctly and thereby avoid pressure sores.

Only one nurse said she knew that physiotherapists also treated leg ulcers. She knew that they used the same electrical treatments as for pressure sores and also that they gave advice on positioning of the legs, general mobility and specific exercises for both the prevention and treatment of leg ulcers.

Physiotherapists' Views

All the physiotherapists interviewed indicated a clear acceptance that physiotherapy had a role to play in the prevention and treatment of pressure sores. They all concentrated on electrical treatments. The modalities mentioned were Ultra-violet radiation (UVR), Infra-red radiation (IRR), Pulsed Short-wave, Ionozone (Vapazone), and Ultrasound. They explained their choice of modality by its effect. They claimed that high doses of UVR and Ionozone desloughed the sore and thereby aided healing. Low doses of UVR, pulsed short-wave, IRR, ionozone and ultrasound improved circulation. When questioned more closely about the healing processes involved, or doses for these modalities, the physiotherapists cited knowledge gained from colleagues - either informally or on a course, or learnt during training. None cited literature or research reports, but some mentioned manufacturers' information supplied with machines as a source of information about dosage and effect. They all claimed good results for their favourite piece of equipment which varied from physiotherapist to physiotherapist. Some machines were claimed to be more effective than others at particular stages of sore formation or healing. However, there was no consensus on their use.

The physiotherapists were aware that the treatment of pressure sores was an area

where they had to work closely with nursing staff. Local arrangements varied over who did the dressings. Some physiotherapists did them at the end of a treatment when this had necessitated the removal of the dressing. These dressings were done to make things easier for the nursing staff and because the physiotherapist felt able to do these well, rather than because they saw dressing procedures as part of physiotherapy.

Other physiotherapists favoured modalities such as pulsed short-wave and ultrasound which did not necessitate removing the dressing from the wound. This avoided any possible conflict with the nurses over doing dressings which some nurses were apparently reluctant to allow physiotherapists to do.

The prevention of pressure sores was seen as a problematic area by the physiotherapists. They all mentioned prevention as a legitimate part of their job, but one they did not find easy to do. The overlap with the nursing staff was mentioned here by most of them. They saw their role in prevention mainly as an advisory one to the nurses in correct positioning and lifting techniques, and in the importance of relieving pressure areas by the correct use of equipment such as sheepskins. However, some physiotherapists expressed a wariness of intruding into an area which might be seen by nurses as theirs - that is an area of nursing rather than physiotherapy expertise.

Improving and maintaining mobility both in and out of bed was mentioned as an important part of physiotherapy's role in the prevention of pressure sores, as was knowing about the effect of neurological deficits such as sensory loss on the potential for pressure sore formation. This was seen as an area in which physiotherapists had expertise to offer but was under-used by nursing staff due to lack of understanding.

All the physiotherapists said that they had treated leg ulcers. They used the same modalities as for the treatment of pressure sores and explained the use of these modalities in the same way. They did not differentiate in their management of these

two types of wounds, apart from including specific exercises (Burgher's exercises) in the prevention and treatment of leg ulcers.

Relationships between Nurses and Physiotherapists

The process of negotiating access to the two settings in which it was intended to carry out the main data collection was an extremely valuable part of the study. The original assumption was that Hospital W would be difficult to access because relationships were acknowledged to be poor and as the researcher was a physiotherapist the nurses in particular would be reluctant to participate in the study. Hospital N on the other hand had a reputation for having extremely good relationships between the two disciplines and it was therefore assumed that less resistance would be met when negotiating access.

However, it soon became apparent that Hospital W was very willing to be part of the research project. It appeared that because it was widely known that there were problems at this hospital, which was going through a period of great change, the managers of both the nurses and physiotherapists did not feel the need to pretend otherwise. They did not feel threatened by the idea of a researcher uncovering things they would rather have kept hidden. It may well have been also that no-one wanted to be seen to be blocking the research, but the level of cooperation seemed to indicate that there was a genuine commitment to facilitate the study.

At Hospital N however, what appeared to be good relationships between the nursing and physiotherapy professions were soon revealed to be a front - erected and sustained by both sides - for extremely poor relationships. Both the nursing and physiotherapy managers pointed the researcher firmly in the direction of a particular ward as being a suitable site for data collection as the relationships there were so good. It was stated that the senior physiotherapist and the ward sister, while both being strong characters and having their disagreements, got on extremely well. This

description was repeated again by both the physiotherapist and the sister concerned who both expressed great interest in the study and a willingness to participate. They were both given ample opportunity to withdraw gracefully from the study at several stages but both insisted they wanted to take part. The negotiations over the data collection process went on over a long period with many delays, but these appeared to be similar delays to those experienced at Hospital W where in the end data collection did begin. However, on the day that the completion of the diary sheets was finally due to begin the researcher arrived at the hospital to be met by a distraught physiotherapist who explained that the sister on the ward had left a message to say that she did not want to take part in the study after all. No explanation was offered as to why she had changed her mind, or why she had left it to this late stage to withdraw.

This incident led to the physiotherapist admitting that relationships with this sister were in fact very difficult indeed. She claimed that she spent most of her time and energy not treating patients but ensuring that the ward sister and her staff were not upset by anything the physiotherapists did. She said that the reason she worked on this particular ward and did not allow any of the more junior staff to work there was because things were so difficult with the sister. An experienced out-patient physiotherapist, she contrasted working in out-patients where there was only the patient to worry about, with working on a ward such as this where most of her working day was directed not towards patients but towards keeping the nurses happy.

It appeared from this and subsequent conversations that this physiotherapist and the ward sister were colluding in presenting a picture to everyone else of an extremely good working relationship, while in fact not working together at all well. The extent to which they were successful can be seen in the fact that the researcher was directed firmly to this ward when it was known that the study was focusing on nurse-physiotherapy relationships. It would be feasible to think that one individual manager might suspect that things were not as they seemed and want the researcher to

investigate the situation. However, whenever Hospital N was mentioned as a possible site for data collection this ward was picked out as a particularly good example of excellent multi-disciplinary working.

One of the contrasts in the physiotherapy services at the two hospitals was the involvement of the physiotherapists on the wards. At Hospital W the physiotherapy department was situated away from the ward area and patients were taken off the ward for some of their treatment. This was mentioned by several of the nurses as a disadvantage as they would have liked to know more of what went on when their patients were having physiotherapy treatment. They knew they could always ask to visit the department and watch the treatments, but said it was not always convenient and meant making a definite decision to take time away from the ward to do so.

At Hospital N there was a large treatment room which geographically was part of the ward. Although it had never been used as a patient day-room it occupied the same space as the day room did on the adjacent wards. What would have been a four-bedded bay was used as the day room instead on this particular ward. This meant that the patients' physiotherapy treatment took place on the ward and not separate from it. This had been negotiated by the physiotherapy manager and the consultant physician when the hospital had first opened and was felt to be an acknowledgement of the value placed on integrated physiotherapy treatment. Nursing staff were able to pop in and out of the treatment room at will to observe what was going on, to administer medication, to pass on messages to patients, or to discuss things with the physiotherapists. It appeared on the surface that everyone valued this easy access and that the advantages of having this room on the ward were accepted by everyone.

On arriving one day to conduct an interview, the researcher found the senior physiotherapist extremely distressed and the interview was postponed. The reason for the distress was that the consultant physician on the ward had just informed the

physiotherapist that the treatment room was going to become the day room for the ward so that there would be another four beds put into the existing day room. The reason given for this was that with the onset of winter more acute beds would be needed to deal with acute chest complaints.

The senior physiotherapist said that there were more complex reasons behind this decision and felt that it was a move by nursing staff to get physiotherapists off the ward. When she asked where patients would go to be treated she was told that there was plenty of room in the out-patient department and that a portering service could be provided. This concept of a physiotherapy service in a separate part of the hospital was very different to the model described by the physiotherapist as being necessary for the rehabilitation of elderly people. When asked why this move to turn the treatment room into a day room had happened now when it had been talked about off and on for fifteen years without it ever happening, the physiotherapist said that the most significant factor as far as she was concerned was that the new unit manager was a nurse and was therefore more inclined to listen to the nurses' point of view and ignore what the physiotherapists wanted. (*see Appendix B for field notes of this visit*).

4.3 Discussion

Three main issues emerged during the analysis of the findings. The first is that neither physiotherapists or nurses have a clear image of physiotherapy. The fact that nurses do not understand what physiotherapy is was not a surprise to the researcher; the fact that physiotherapists do not appear to know what they do was. The second major finding was the extent of the poor relationship between the two professions. Two settings were chosen on the basis that one was an example of poor relationships and one was an example of good. The findings showed that even where a lot of effort is put into making it appear that relationships are good they are in fact problematic. The third issue is that of the models of care used by the different individuals involved in delivering health care to elderly people in hospital.

Physiotherapy Practice

The extent to which the physiotherapists were unable or unwilling to describe their practice was surprising. One explanation is that as the researcher was a physiotherapist they felt that it was obvious what they meant by words such as rehabilitation. It may have been that they felt anxious that they would not say the right things if they went into too much detail and so left it to words that could be interpreted in many ways. However, this was not the impression that was gained during the interviews. The physiotherapists seemed genuinely unable to describe their practice. The only one who seemed able or willing to expand on what she did was a newly qualified junior physiotherapist who described her job in a fairly mechanistic way.

The only thing that was mentioned as definitely being physiotherapy and something that no-one else was allowed to do was electrotherapy. This area of physiotherapy seemed to be used as a fall-back position when physiotherapists were pressed to describe what was unique to physiotherapy. This does not give the impression of a profession that has a clear professional identity. These physiotherapists had problems describing what it was they did that no-one else could do. It could well be that this is limited to the area of care of the elderly and that physiotherapists working in other specialities or settings have a clearer understanding and can be more articulate about what they do. In care of the elderly however the physiotherapists interviewed found it difficult to explain their role.

The fact that nurses had trouble describing what physiotherapists did is not surprising given the problems physiotherapists had in describing what they do. The limitation of their knowledge to that acquired from personal experience is mirrored elsewhere in the health service as there is little formal education about the role of other health care workers during professional training for all disciplines. It supports one of the original reasons for undertaking this study - the belief that nurses know little about what

physiotherapy has to offer elderly patients.

Professional Relationships

The discovery that relationships between nursing and physiotherapy staff on the ward at hospital N were so bad was a shock. This ward had been recommended by colleagues, managers, physiotherapy teachers, and medical staff as a shining example of good practice in multi-disciplinary working. The depth of bad feeling and the extent and success of the cover-up was clear once the barrier had been broken. The fact that no data collection through the diary sheets was ever carried out was not an issue in the end. It seemed that having to put into action the multi- disciplinary working that was talked about so freely was too much of a charade and led to a withdrawal from the study of the nursing sister. While she offered no explanation as to why she was not prepared to cooperate, and it could be that there were other sound reasons why it was not feasible to carry out the data collection, the withdrawal of her cooperation led to a breakthrough in the acknowledgment by the physiotherapist that all was not as it seemed.

It would appear from the limited extent of the study that relationships between nurses and physiotherapists can be problematic even where a lot of effort is put into making it appear that everyone works together very well. Indeed, it may be that the effort that is put into keeping up the appearance of good relationships prevents the real issues being tackled. At Hospital W, where the poor relationships were acknowledged and accepted by everyone, the two professions seemed to find ways of working towards improving these relationships. The managers of both nurses and physiotherapists at Hospital W said independently of each other that there was no doubt that things were improving and that the tensions that had been evident two years before the study was undertaken seemed to be dissipating.

At Hospital N, where it was difficult for the staff involved to admit to problems over

multi-disciplinary working, relationships were deteriorating. This was evident in the ward selected for data collection being in effect a no-go area for junior physiotherapy staff, in the ultimate refusal of the ward sister to be involved in the study, and in the decision to turn the physiotherapy treatment room into the patients' day room thereby effectively removing physiotherapy from the ward.

Models of Care

The third issue that emerged from the data is that different professionals deliver care to the same patient, in the same setting, with the same ultimate objective, but using different models of care.

At Hospital W the nurses had spent two years examining their own practice and moving over to what they described as a wholistic model of nursing. They had adopted the system of primary nursing which involved clearly identifying the nurse responsible for each individual patient and making the care-giving totally patient-centred. All the nurses employed on this ward had had to think through the issues involved in this type of care-giving and they were all committed to it as the most beneficial way of nursing elderly people. The physiotherapists however had not been included in any of the strategies used by the nurses to resolve problems associated with the change to primary nursing.

No-one appears to have acknowledged that by changing the way nurses were nursing they were also changing the way an effective physiotherapy service could be delivered. Nurses on this ward were delivering care within a model that was understood and accepted by all the nursing staff on that ward. The beliefs inherent in the model had been clearly identified and much time and effort had gone into ensuring that those beliefs were common to all the nursing staff. No-one appeared to have involved physiotherapists or other therapy staff in the process of defining and agreeing a common model and yet it was expected that they would be able to adapt

their ways of working to accommodate major change.

There were long-standing problems at this hospital over the delivery of the physiotherapy service. As well as providing a service to the wards the physiotherapists also ran a busy out-patient department. The superintendent physiotherapist was seen as very out-patient orientated and as putting the wards low on her list of priorities. The superintendent physiotherapist herself said she saw no difference between elderly patients and anyone else and said that she aimed to provide the best physiotherapy treatment possible for the condition, irrespective of the age of the patient. This statement, made by the physiotherapist as an indication of a high quality service, was the pointer towards examining the models of care that physiotherapists were using in their practice.

This individual identified her main expertise as an out-patient physiotherapist and remarks over treating conditions irrespective of age, and treating elderly patients just like anyone else, indicated an adherence to a medical model of care. She talked about treating conditions rather than people and about physiotherapy as something that was done to patients to cure them. There was therefore a difference in the model aspired to by the nursing staff with its mentions of holism and humanism, and that used by the physiotherapist working on the ward.

One of the very interesting manifestations of the conflict between the two different models was the issue of uniforms. As part of the change to primary nursing the nursing staff had agreed to move out of uniforms and to wear their own clothes (mufti). This is an integral part of primary nursing and is intended to break down the barriers between professionals and patients and allow a more equitable relationship to evolve. The physiotherapists and occupational therapists were expected to come out of uniform as well but this move met massive resistance from the physiotherapists. Many different reasons were given as to why it was not appropriate for them to wear

their own clothes - mainly related to the belief that it was a denial of their professional status. As a single issue it caused more upset, as it allowed the physiotherapists opposition to the concepts of primary nursing to be vocalised, than any other issue related to the changes on the ward. It was seen by the nursing staff as indicative of physiotherapists' unwillingness or inability to change or to be involved in holistic care giving, and by the physiotherapists to be indicative of the primary nurses executing a take-over of all care-giving on the ward.

At Hospital N the physiotherapist appeared to be operating much more within a holistic framework. She was committed to care of elderly people as a speciality and spent a lot, if not most, of her time trying to ensure continuity of treatment and integration of physiotherapy concepts into the patients' entire day. While there was not a lot of evidence to clearly indicate that she was delivering a service within a non-medical framework there were pointers to the fact that she believed there was more to physiotherapy with elderly people than just doing things to them to make them better. Perhaps most significant was her distress that the new arrangements would mean that patients went down to the out-patient department to have their *'daily dose of physiotherapy'* before returning to the wards.

The nurses on the ward in Hospital N appeared to be delivering care in a very traditional, medically orientated way. The structure was very hierarchical, in contrast to primary nursing. Team nursing was still in operation which meant that patients had different teams of nurses looking after them with little continuity. The ward sister was still very much in charge and no-one seemed prepared to take decisions without referring to her. Although some new nursing procedures had been adopted, such as Problem Orientated Medical Records, there were indications that such changes were not welcome but seen as management fads. The uniforms worn on the wards were very traditional, with elaborate hats and clear differentiation between grades of nursing staff. Ward rounds by the consultant physician were conducted in a very

formal way and preceded by an inspection by the ward sister to see that everything was ready for his arrival. In all, the setting was very formal, traditional and one in which medical concepts were sacrosanct. It may be that the non-adherence of the physiotherapist to this model was the source of the conflict.

The two settings provided contradictory images of philosophy and culture. In one, physiotherapists worked to a medical model of care alongside nurses who had adopted a holistic approach. In the other, the nurses worked in a task-orientated medical setting which appeared to frustrate the physiotherapists' adoption of a more holistic delivery of care. It is suggested therefore that professionals not sharing the same model of care-giving are likely to experience conflict when they attempt to carry out work which requires close professional interaction. As this close professional interaction is a part of work in a multi-disciplinary clinical team, which is advocated as the best means of delivering effective care to elderly people, it would appear likely that any tensions and conflicts between groups of professionals would be highlighted on wards for elderly people.

This discovery of the issue of conflicting models led to a desire to discover what models of health and health care physiotherapists understood and adhered to in their practice. It seemed to hold the key to the issue of inter-professional conflict but was also of great interest as a way of discovering what physiotherapy actually is and what the practice of physiotherapy actually entails. The work for the next phase of the research therefore concentrated on discovering the theories inherent in the models of health described in the literature and the theories underpinning physiotherapy practice.

5. MODELS OF HEALTH CARE

Health care literature identifies two types of models. One is a descriptive model which enables current and past health care practice, such as nursing, to be described and can be equated to the definition of a model as 'a simplified description of a system to assist calculations and predictions.' (Concise Oxford Dictionary 1990). The other is a theoretical model which is used to explain health care by examining the beliefs which underpin its development and delivery. The theoretical models found in the health related literature are examined in detail as a framework to explore physiotherapy practice in relation to the theory which underpins it.

The theoretical models which have been identified in the literature as relevant to the practice of health care are biomedical, economic, behavioural, materialist, geographical, social and holistic. These are described below with a brief examination of the consequences of accepting the beliefs from which they arise. A further discussion of the consequences of adopting one or other model for physiotherapy practice is included later.

5.1 The Biomedical Model

Several authors have argued that the beliefs and assumptions inherent in the biomedical model have dominated the development of medical theory and practice. (Engel 1977, Mishler 1981, Eyles and Woods 1983). Its dominance has resulted in more work being done on analysing the underlying assumptions and consequences of this model than any other. Writers such as Mishler argue that this has led to it being treated as '*the* representation of reality not just one representation'. (Mishler 1981).

Mishler (1981) identifies four assumptions of the biomedical model. To these four are added a fifth by Eyles and Woods (1983). Pratt (1989) echoes these but with a

different perspective which is shared by Rogers (1970) who relates the development of theory in medicine to Cartesian dualism.

Normal/Abnormal

Fundamental to the medical model is the concept of there being such a thing as normal, and therefore that deviations from this are abnormal. Disease is defined as a deviation from normal biological functioning. The concept of normality is an essential element of the biomedical model but there is no consensus in the literature as to what constitutes normal. Indeed, the validity of normal and abnormal as objective measures has been widely challenged by many writers. Mishler (1981) stresses that normal can be defined either in terms of average or mean, or as an ideal. Ryle (1961), partly through his work on the size of thyroid glands in different populations, came to the conclusion that normal has to be defined in relation to social and environmental factors. The key issue identified is that what is normal within one culture and at one time in history may not be normal within another framework (Ryle 1961, Illich et al 1977). Similarly, the literature on the emergence of the disability movement (Finkelstein 1981, Davis 1990) challenges the equating of normal with usual or average and the consequential equating of unusual or different with abnormal. Without a clear definition of normal the concept is meaningless, or at best of little use in informing practice. However, it underpins the framework within which the medical model exists.

Specific aetiology

Mishler (1981) uses the term specific aetiology to describe the belief in a causal relationship between specific diseases and identifiable agents. He claims that the work done by Pasteur and Koch in the 19th century, in demonstrating that specific diseases could be produced by specific micro-organisms, dominated the development of medical thinking, and led to the search for a specific aetiological agent for each identified disease. The identification of a causal agent is now considered central to

advances in medical knowledge about a particular disease. Mishler claims that this doctrine, which led to the development of the germ theory, has become integral to our understanding of illness and disease. So powerful and influential is the germ theory that the concept of a specific identifiable agent as the cause of disease has spread from infectious disease to all aspects of ill-health.

The limitations of this approach are discussed by Eyles and Wood (1983) who argue that this simple cause and effect model cannot adequately explain why specific individuals in specific places are sick or ill, Dubos (1963) who claims that there are few cases in which the discovery of a specific aetiological agent provides a complete account of the cause of the disease, May (1961) who argues that the impact of pathogens alone is not sufficient to cause disease which depends on those environmental factors which he identifies as geogens, and Engel (1962) who stresses the multiple and interactive processes involved in the development of ill-health.

Generic disease

The concept of generic disease is that diseases are specific entities that exist outside cultural and historical limits rather than being useful man-made labels to hang on groups of symptoms. This places diseases outside social, geographical and environmental factors and defines them as entities which exist across all cultures and in all time. It depends on, and is a natural progression from, the first two assumptions that diseases are deviations from normal biological functioning with specific causal agents.

Its limitations are expounded by Balint (1957), Engel (1962), Dubos (1963). Fabrega (1976), Ehrenreich and English (1976), Mishler et al (1981), and Eyles and Woods (1983). In particular Engel argues that as conventions change what is considered as illness or disease at one time is not so considered at another. Ehrenreich and English (1978) use the example of menstruation to illustrate this point when discussing

medicine as a means used to control women. Menstruation had been defined as an illness within certain cultural contexts and therefore a legitimate area for medical intervention. Differences in disease descriptions or terminology between different cultures and periods of history are explained, by those who adhere to this theory, as differences in knowledge and understanding, rather than equally valid explanations of phenomena. The emergence of 'new' diseases is linked to new causal agents such as mutant viruses rather than being new explanations of symptoms which have always been present in the world population. Adherence to this concept has been the main factor in influencing the development of contemporary medical practice where the focus is the disease rather than the person.

Scientific neutrality

This concept is absolutely crucial to the maintenance of the hegemony of medicine. The belief is that medicine is based on science and that science is politically, culturally and historically neutral (Mishler 1981). Rogers (1970) explains this link between science and medicine as arising out of the theory of Cartesian dualism, but does not develop this idea to any great extent. Scientific objectivity or neutrality is held to be paramount and is the justification for the domination of health practice, education, and research by medicine.

Sequential progress

Eyles and Woods (1986) add one more assumption in their analysis of the biomedical perspective - that medical knowledge advances in a linear fashion. Sequential progress is the term they give to the belief in the acquisition of a body of knowledge in terms of a sequence of steps. Knowledge is acquired, a problem solved, and that knowledge is then in place as a foundation for the next piece of knowledge. Progress is seen as logically and objectively determined by the uncovering of pieces of knowledge which when placed together will lead to some ultimate truth. However, this does not explain the different levels of knowledge and understanding of different

cultures, or the loss of knowledge by civilisations which were less advanced than their predecessors.

Pratt's analysis of the medical model is less complex than Mishler's but contains four essential elements. The first is that this model is based on the fundamental law of natural order which states that events occur in regular and predictable ways and that bodily processes can be expected to follow certain physiological laws, themselves supported by more fundamental laws such as those of physics and chemistry. The second assumption is that the body is a mechanism and therefore subject to laws of mechanics, the third that intervention is aimed at individuals in a struggle against identified disease, and the fourth that the medical model is heavily, if not exclusively, invested in science. This analysis echoes that of Mishler (1981) and Eyles and Wood (1983) but with a clearer indication of the origins of the relationship between the development of this model and the philosophical arguments which influence it. In particular the influence of Descartes is identified and the link made between dualism, mechanics and the development of medical theory. As such it makes an important contribution to linking the biomedical model to Cartesian philosophy and is supported by Lewis (1962) and other commentators on Descartes.

Cartesian philosophy

The 17 century philosopher Descartes started his philosophical journey from Galileo's premise that nature consists of mathematical facts (Ryle 1949). Galileo used mechanical laws to explain movements in space as the effects of other movements in space. Descartes developed this into the premise that what is real and intelligible in nature can be measured and quantified and that only when phenomena are reduced to mathematical terms are they perfectly rational and therefore completely real (Lewis 1962). Lewis claims that Descartes substituted mathematical and mechanical explanations for the doctrine of final causes which was the predominant philosophical theory of the time.

Lewis's analysis makes clear the link between the mathematical foundation of Descartes' work and his development of the mechanistic approach. Lewis claims that this was the most radical and influential revolution in the history of thought from Aristotle to Kant. It gave the 'all clear' to physical science and provided a philosophical framework or world view which explained and justified the world in mechanical terms.

Dualism

Dualism is the name given to that part of Descartes' philosophy which identified a split between mind and body. Mind and matter, according to Descartes are two fundamentally distinct substances:

> "Mind which does not occupy space, whose sole property is to think; and matter, which does not think, but is extended (spatial) substance." (Lewis 1962 p91).

Ryle (1949) used the term "Descartes' Myth" when discussing dualism and related the concept of the separation of mind and body to the concept of cause and effect. He explained dualism as the belief that there are in body and mind two existences - one internal and one external. The external occurs in a common field - space - and is connected to what happens to other bodies in space. The internal occurs in insulated fields - minds - with no direct causal connection between one mind and another. Ryle believed that the fundamental flaw in this analysis lay in Descartes' belief that mind and matter are terms of the "same logical type". The dominance of this idea in modern society and subsequently modern medicine is evident in the development of separate professions dealing with matters relating to the mind and matters relating to the body.

In order to provide a practical example of dualism and show how the human body operates as a machine without the need for the soul or mind to be involved, Descartes

modified Harvey's description of the circulation of the blood around the human body (Descartes 1637). This division between mind and body led Descartes to regard the human body as belonging to science, and the conscious mind to be the natural property of philosophy and religion. Heawood (1967) argued that this weakened each of the disciplines by limiting its sphere of thought.

Reductionism

Having separated mind and body, by defining them as entities which occupy different spheres of existence, Descartes then developed reductionism as his method of choice for the advancement of knowledge. Cartesian philosophy views the physical body as a machine, subject to mechanical laws. An examination of the individual parts of this machine will lead, according to this theory, to greater knowledge of the workings of this machine, and therefore to a greater understanding of how human beings function as a whole. (Descartes 1637, Ryles 1949, Lewis 1962, Henry 1997).

This placed the study of the human body within mechanistic philosophy, subject to the laws of natural order and cause and effect. The underlying concept of this approach is that man is a machine that can be explained by physical laws. Henry claims that Descartes used his explanation of the working of the heart to develop:

> "...a speculative physiology in which animal and human bodies functioned like complex automata based on hydraulic systems." (Henry 1997 p68)

The connection between the methods developed by Descartes and medicine is the belief that all knowledge can be gained by scientific enquiry which should therefore be applied to all sciences, including in particular medicine. Descartes was scornful of the contemporary state of the knowledge of medicine and believed that his methods would allow great advances to be made. Indeed he advocated the study of medicine as one of the main uses of his methods of enquiry as this would lead to :

> "the preservation of health which is no doubt the chief of all goods and the foundation of all the rest in this life ..... if a way can be found of making men wiser and more skilful than they have so far proved I believe we must look for it in medicine." (Descartes 1637 cited Henry 1997).

A connection between the objectivity of science and the study of medicine is set out in the analyses of the biomedical model cited above, but they do not make clear the progression from Descartes' method of enquiry, his application of this to the workings of the human body and then his decision to apply his methods to medicine. This renders them incomplete as analyses, although they provide a framework for examining the effect of Descartes' work on the development of modern medical theory.

Consequences of the Assumptions of the Medical Model

Pratt argues that the dominance of the mechanistic assumption of the medical model means that intervention is aimed at individuals and emphasises treatment and cure in a struggle against identified disease. This removes medicine from society by claiming that it should be objective and neutral to be a true science. The implication of this is that the work of physicians is guided by objective scientific rules and is independent of social, cultural and political forces. This obscures the connection between illness and society. In other cultures treatment involves solving social as well as individual conflicts. Fabrega (1976) claims that science has provided Western culture with disease forms which on logical grounds are not connected to the social fabric.

One result of the study of the human body being defined by Descartes as the natural property of science is that the wholeness of the person is lost. A mechanistic approach reduces the body to its constituent parts and Friedman argues that the scientific method is not able to do other than that (Friedman cited Buber 1965). The inappropriateness of using the scientific method to discover the 'wholeness of man' is echoed by Buber (1965) who argues that only a participative approach will allow insight to be gained. Henry (1997) notes the seemingly insuperable difficulties of explaining the extreme

complexities of living things in mechanistic terms, but says that in spite of this the mechanical philosophy was embraced wholeheartedly by medical practitioners.

5.2 The Economic Model

Eyles and Wood (1983) describe a model based on the premise that health is a capital good, an individual's stock of which depreciates over time. This stock can be increased by investment, the key variables of which are diet, exercise, housing, consumption habits, environmental factors, education and information - all of which are under the control of the individual. If an individual's income increases then investment in health is likely to rise. The market, as the supplier of health care, responds to consumer pressures and health becomes a matter of the deliberate consumption of goods and services. It is shaped by individual preferences and consumer decisions about spending. As its name implies, this model is based on the assumption that health is a commodity that can be bought and sold and the prime factor in determining health is the amount of money an individual has available and chooses to spend on acquiring it.

5.3 The Behavioural Perspective

This model focuses attention on the individual, his social attributes and aspirations (Eyles and Wood 1983). Social and psychological variables are key elements of this model rather than just economics. The result of this approach is that what is gained from health care depends not just on what is available, but on the expectations of the individual. There are parallels with the economic model in that it is concerned with the motivation of individuals, but assumes that social and psychological pressures are more important than monetary ones. In the Health Divide (Whitehead 1987) this model is described as being based on the assumption that inequalities in health evolve because lower social groups have adopted more dangerous and health-damaging behaviour than the higher social groups.

5.4 The Materialistic Perspective

The belief underpinning this model is that the social, economic and political structures of society are the major factors in shaping health care (Eyles and Wood 1983). Similarly, Illich (1977) argues that industrialisation is the main shaping zone of society and that only those illnesses and diseases which affect productivity are considered worthy of investment in terms of health care. He further argues that as medicine is an agency which carries a world-view or hegemony throughout society medical ideas develop to support the dominant interests of the establishment. This is echoed by Eyles and Wood who describe this perspective as being concerned with the societal effects and implications of the enmeshing of medicine and health care in the wider society.

The Health Divide (Whitehead 1987) describes the structuralist/materialist approach as emphasising the role of the external environment in health. Poor housing, dangerous work and unsafe play areas for children are environmental factors which will all contribute to inequalities of health. However, the authors emphasise the difficulty of differentiating accurately between behavioural and environmental factors and claim that the two explanations are interdependent. It is worth noting in particular the assumption that health issues under this perspective are political in contrast to the assumption of the biomedical model that health is apolitical.

5.5 The Geographical Perspective

This model developed from the use of medical cartography to demonstrate the spatial patterning of illness. It is based on the assumption that there is a causal link between disease and environmental conditions - particularly the rural/urban factor. Mathematical models are employed to plot the spread of disease and determine links between disease and the environment. It follows therefore that political and economic

decisions can be made on the provision of health care delivery systems related to geographical factors rather than social class or individual wealth. With this model it is where an individual lives which is the primary factor in determining their health status.

5.6 The Social Model

One consequence of the assumption of the medical model that disease is a deviation from normal is that anything which is not 'normal' can be legitimately claimed by medicine as an area which it should control. Disability, as a deviation from normal, is therefore equated with illness and comes under the remit of health care workers, specifically doctors.

> "The attitude that a disabled person has 'suffered' a personal loss is a value judgement based upon an unspoken acceptance of the standard being able-bodied normality."
> Finkelstein (1979 p2).

A challenge to this perspective comes from Finkelstein's analysis of disability as being socially determined. He argues that disability is not a consequence of an individual's impairment but of society's physical construction by non-disabled people. Changes brought about by the Industrial Revolution meant that physically impaired people were not able to remain productive once the demands of travel and access were imposed by changing work practices. People who had previously been productive became isolated at home, then segregated into institutions. This allowed the development of the structures of society, the physical fabric of cities, the design of buildings, to be dominated by non-disabled people with no account of the needs of the now invisible non-ablebodied. Physically impaired people thus became disabled by the structure of society. (Finkelstein 1979).

A practical example of this is described by Meyerson and Scruggs (1979):

> "The reason why students in wheelchairs are unable to take chemistry or physics in college is not because the lab benches are too high for them to reach but because society has provided suitable environmental supports for some of the population and not for others. There are no natural laws or necessary conditions that require lab benches to be 50 inches high rather than 24 inches high." (p60)

Finkelstein describes three stages or phases to this process. In phase one physically impaired people were socially active and able to earn a living in cottage industries or by begging. The social changes brought about by the Industrial Revolution led to physically impaired people becoming part of a lower social strata together with unemployed, low-paid and mentally ill people. Begging was a socially acceptable way of acquiring an income. However, able-bodied people were often found impersonating cripples to increase their earnings as beggars. The Society for the Suppression of Mendicity was formed in 1819 in an attempt for weed out people with genuine impairments from imposters. This marked an early attempt to isolate cripples into a special class and saw the beginning of a differentiation of attitudes - cripples' poverty was as a result of personal misfortune, that of the able-bodied was due to indolence.

Phase two was related to the emergence of hospital based medicine which enabled the segregation of large numbers of disabled people. Physically impaired people were seen as passive, needing others to do things for them:

> "That many people come to view themselves in this manner even today is a reflection of the pervasive success of the 'institutional phase' in the history of disability." (Finkelstein 1979 p10)

Advances in medical practice led to larger numbers of disabled people surviving and strengthened the connection between disabled people and institutions as well as facilitating medical dominance. Workers in hospitals were sucked into servicing

disabled people and in time these "paramedical" workers spilled over into the custodial institutions. The focus of attention of this second phase was firmly on the physically impaired individual. Phase three, which Finkelstein claims is just beginning, focuses on the nature of society which disables physically impaired people. He describes it as the beginning of a struggle to reintegrate people with physical impairments into society.

Meyerson and Scruggs (1979) liken Finkelstein's three stages of disability to the linear models of St. Augustine and Karl Marx. St. Augustine's Eden and Marx's primitive communism relate to Finkelstein's phase one of disability; Mosaic Law (St.Augustine) and capitalism (Marx) are phase two; Paradise (St. Augustine) and communism (Marx) are phase three. This model is characterised by the initial stage being superior to the second stage and predictive of the final future stage of utopia.

Stubbins (1979) and Meyerson and Scruggs (1979) disagree with Finkelstein's historical analysis of phase one as being halcyon days when cripples were integrated into society. Stubbins in particular proposes the idea that economic advances in society have benefited disabled people far more than they have disadvantaged them. This argument ignores Finkelstein's point that disabled people missed out on economic advancement in the first place because they had been removed from the economic scene by the Industrial Revolution. Stubbins' concept of disabled people benefitting from the economic advancement of society depends on the efficiency of the cascade system of wealth distribution down through the class structure. The effectiveness of this as a means of improving the economic well being of significant parts of society is arguable.

The Consequences of the Social Model of Disability

This model is a challenge to current definitions of impairment, handicap and disability. It is primarily a polemic model - designed to effect a change in society's attitude to

disabled people. As such it is still developing the theory on which it is based and will have to undergo much refinement before it is a complete explanation of the experience of disabled people. However, it has built on earlier work of, for instance Illich, Zola and McKnight (1977), and is being increasingly cited in relation to the development of alternative theoretical models of health. It is therefore worthy of further examination.

If the principles underpinning this model are accepted then the resources channelled into rehabilitation services are misdirected. According to Finkelstein it is these very services which maintain the status quo - that of a disabling society. Economic self-interest, socialisation and academic rejection of non-empirical data are some of the factors which prevent health care professionals challenging the current system. It is in the interest of these professionals to reinforce the notion that the cause of disability lies within the person rather than in the physical and social construction of society. It is not in their interests to challenge a system which provides them with jobs, status and power.

This issue of control is one which has been used to examine the role of medicine in society by writers such as Illich, Zola and McKnight (1977). These authors argue that professions create a need that only they can satisfy and that medicine claims a monopoly over the definition of deviance and the remedies needed. Zola in particular claims that medicine has become a major institution of social control by becoming involved in more aspects of life than any other discipline or institution. The development of genetics as a branch of medicine allows control over unborn lives, while normal processes such as ageing and pregnancy now have their own medical specialities.

Stubbins (1979) argues that recent challenges by psychologists and sociologists in the United States of America to the medical tradition has resulted in a radical movement which rehabilitation professionals should join, but he points out that this will be

resisted by those professionals who want to enhance the status of practitioners for economic returns. He is critical of Finkelstein's totally anti-rehabilitation stance and acknowledges the contribution of medicine, electronic engineering and bio-mechanics in increasing the independence of disabled people. He is more optimistic than Finkelstein that a new role can be found for professional helpers.

Finkelstein's methodology is phenomenological and is based on the premise that the reality of disability lies in the interaction between people and their environment. This is at odds with the natural science that locates disability in the disabled person:

> "Establishment science has deployed virtually all its resources in studying disability and rehabilitation as clinical enterprises, that is as if the individual suffered a disease called 'disability'." (Stubbins 1979 p90)

The implications of this are that in order to study issues of disability within the framework of the social model, methodologies must be developed and used which employ phenomenological approaches rather than those which are rooted in natural science.

> "...mainstream knowledge of disability is tainted by the phoney objectivity of researchers and the practitioners of rehabilitation." (Stubbins 1979 p90).

Stubbins argues that Finkelstein has clearly shown that new truths about disability will only emerge when scientific methods and beliefs have been suspended. However, he is critical of Finkelstein's categorisation of people into the exploited (disabled people) and the exploiters (professionals). This ignores the fact that everyone is dependent on others and on technical aids and that the division of labour demands the development of experts and therefore the potential exists for exploitation of and by everyone. McKnight (1981) reinforces the idea that professionals have a vested interest in

creating disability which then allows them to define and control remedies:

> "You (the patient) are the problem and I (the therapist) am the answer ... only I have the language to understand both the problem and the remedy."
> (McKnight 1981 p12)

Furthermore, McKnight accuses health care professionals of hiding behind symbols of love and care which obscure the economic interests and disabling characteristics of rehabilitation services.

Davis (1990) argues that definitions of disability are of deep political significance. The World Health Organisation (WHO) defines impairment, disability and handicap from a medical perspective - that the impairment from which disability and handicap arise lies within the "psychological, physiological or anatomical structure" of the individual (WHO 1980). This definition is used as the basis for work carried out by the Office for Population and Census Surveys (OPCS). Davis argues that this is ultimately a definition which suits the able bodied establishment and allows information to be collected, analysed and used to maintain disabled peoples' dependence.

A rejection of the medical model of illness and disability would necessitate a redefinition of the World Health Organisation's statement on impairment, disability and handicap. Davis argues that such a redefinition would have far reaching effects in terms of the disability industry. Indeed he claims that it was new definitions by the Union of the Physically Impaired Against Segregation (UPIAS) which allowed disabled people to directly challenge for the first time "the iron grip of able bodied control of disability" (Davis 1990).

The two main consequences of the adoption of the social model of disability are the

challenge to health care professionals to redefine their role, and to researchers to develop appropriate methodologies:

> "Finkelstein makes it difficult for researchers, practitioners and administrators to pursue the typical models of rehabilitation with the innocence they have until now." (Anonymous contributor to conference proceedings 1979).

The irony of the ultimate challenge of this model to professional health care workers is that its acceptance in its current form means that they are no longer part of the solution, but part of the problem. Finkelstein (1984) argues that the crisis in rehabilitation is deepening because of a realisation by professionals of the failure of their services to significantly improve the situation of disabled people.

5.7 Holism

The term holism (or wholism) is defined by the Oxford English Dictionary (1990) as follows:

i. the theory that certain wholes are to be regarded as greater than the sum of their parts;

ii. the treating of the whole person including mental and social factors rather than just symptoms of a disease.

The first definition originates from Smuts' study of the political situation in South Africa after the Boer wars:

> "...we were left fragments out of which we were to make a whole ... we have seen emerging out of these discordant elements the lineaments of a new South Africa ... the biggest problem facing us [is] being solved along holistic lines." (Smuts 1926 cited Smuts 1952 p56).

Holism arose out of Smuts' search for patterns in chaos, guiding laws in nature and science, and a larger view which would enable the whole to be seen. He held that the

development of scientific thinking had led to the realisation that the world was not made up of substance but of flexible changing patterns. The idea that matter is determined by its constituent elements had to be abandoned as the reality of things lay in their wholes not in their parts.

> "If you take patterns as the ultimate structure of the world, if it is arrangements and not stuff that make up the world, the new concept leads you to the concept of wholes. Wholes are not stuff; they are arrangements. Science has come round to the view that the world consists of patterns, and I construe it to be that the world consists of wholes." (Smuts 1926, cited Smuts 1952 p220).

The next stage in the development of this theory was the concept that a whole had a force greater than the sum of its individual parts and that this allowed progress to be made. Smuts argued that if equality between cause and effect was accepted then the world would have remained as it was in the beginning. Holism postulates that slightly more is produced in the effect than was contained in the antecendent cause. This allows for "an infinity of increments" and therefore the "additional building of creation".

An inherent part of holism is that detail receives most of its meaning from the whole of which it is part. A part only has meaning in relation to the whole. A reductionist approach is therefore of limited value as the part can only be examined and found meaningful as a member of the whole. This view is echoed by Hawking (1988):

> "If everything in the universe depends on everything else in a fundamental way, it might be impossible to get close to a full solution by investigating parts of a problem in isolation." (Hawking 1988 p13).

The adoption by medicine of holism as a useful theoretical model on which to base practice seems to have lead to a redefinition of Smuts' ideas, but without a theoretical justification for the redefinition (OWLS 1992). The second part of the Oxford English

Dictionary definition of holism as the treating of the whole person, including mental and social factors echoes Smuts' argument that it is the whole that is important, not the parts. However, the use of the word 'including' in that definition identifies the split between Smuts' concept of holism and medicine's use of the term.

The British Holistic Medical Association (BHMA undated leaflet) acknowledges the shortcomings of the reductionist approach and questions the usefulness of the biomedical model in understanding the functioning of the parts within the whole person. It acknowledges that people are multi-dimensional and that a range of interventions at a variety of levels may be relevant. It argues that the systems of the body are interrelated and that the mind-body split of dualism is largely an illusion. Significantly it argues that no one individual practitioner will have all the answers but that holistic healthcare will be best provided by multi-disciplinary clinical teams. Reference is made to Engel's development of a biopsychosocial model (Engel 1977) as one way of addressing the problem of biomedicine not answering people's needs. This acknowledges that medicine, and associated health care professions cannot rely on the medical model and its focus on physical disease to answer people's health needs. The holistic model is referred to as a better or more advanced way of providing health care. However, the assumption behind this acceptance is that holism is synonymous with the biopsychosocial model. The argument seems to be that as long as you look at people's psychological and social needs as well as their biological functioning then you are using a holistic approach.

Bevis (1978) describes this approach as summative dualism and argues that it is not a holistic approach but an attempt to counter accusations that professionals do not see patients as whole beings. Summative dualism is the adding together of various aspects of the patient - usually physical, mental, spiritual and social to make a biopsychosocial model. The influence of this on nursing theory can be seen, according to Bevis, in the development of descriptive models which are essentially the medical model with

threads of other things woven throughout. It is also clearly evident within physiotherapy. The 1991 Curriculum of Study (CSP 1991) mentions 'the holistic approach to patient care' with no indication of what was meant by this term and no discussion was had about its use in the working party that wrote this document (McCoy 1992 personal statement). However, in the 1996 Curriculum Framework holism is defined as an approach which:

> "... takes into account the biological, psychological and emotional circumstances within an environmental context." (CSP 1996)

Pratt (1989) uses the Concise English Dictionary (1982) definition of holism - the tendency in nature to evolve wholes that are greater than the sum of their parts - to relate holism to physiotherapy practice. Again the focus is on recognising the importance of the mental, social, emotional and spiritual aspects of a person in addition to the physical. He introduces the idea that wholeness may be seen in other cultures as a balance of forces. However, the implication of accepting that the whole is greater than the sum of the parts is not explored by Pratt.

The Consequences of the Holistic Model

The relevance of holism to health care practice is described by Pratt as allowing patients to become responsible adults taking an active part in their own rehabilitation. Self-care and health education are two of the consequences of the holistic approach described by Pratt and echoed by the British Holistic Medical Association (BHMA):

> "In the holistic model patients are seldom passive recipients of therapy, and will usually need to become engaged in a process of change."
> (BHMA promotional leaflet undated).

Pearson and Vaughan (1986) contrast the consequence of the assumptions of holism - that there is a need in medicine to study the whole being - with Descartes' proposition that the body as a machine can be broken down into its constituent parts for

meaningful study. They cite Byrne and Thompson (1978) who used the phenomenon of water to illustrate holism. Hydrogen and oxygen can be studied as the constituent parts of water and it will be found that oxygen supports combustion and hydrogen is explosive. However, a study of the whole, water, leads to the discovery of a different property - water extinguishes fire. Wright (1986) explores the relationship between holism and the practice of nursing and argues that merely taking into account social, physical and psychological factors is not enough, and may lead to the ignoring of the total nature of the person.

These writers have therefore accepted the limitations of the summative dualism described by Bevis (1978) and have identified the need for medicine (or at least nursing) to examine the whole person rather than the constituent parts. However, the resulting tension between a philosophy, the acceptance of which would demand a radically new approach, and the practice of medicine, and related activities, which are based in mechanistic reductionist theories is not identified. The ultimate consequence of an adherence to holism by medicine, nursing and related professions would be the destruction of much of the structure upon which education, research and practice is based. If the inappropriateness of the study of constituent parts were accepted, much of the syllabus of medical schools - anatomy, physiology, dissection - would be rendered meaningless. It is therefore in the interests of medicine to define holism not in terms of the whole being greater and essentially different to the sum of the parts, but in terms of summative dualism or the biopsychosocial model. This retains the essential nature of reductionism and can therefore be absorbed into medical theory without threatening its foundations.

5.8 Discussion

What Mishler (1981) calls models, Eyles and Woods (1983) term perspectives and Whitehead (1990) describes as explanations are all frameworks for discussing

assumptions made about the origins of disease and ill health. Some or all of the elements that could potentially contribute to illness can be found in the various modes. The significant difference between the models is the importance or weight that is given to individual or groups of assumptions within that model. For instance those ascribing to a bio-medical model may accept that social, environmental or psychological factors play a part in illness but will give most weight to pathogens as the cause of disease and therefore will concentrate resources on their discovery and elimination.

Other perspectives give greater weight to factors other than pathogens as determinants of ill-health. As discussed above, the biomedical model is not the only way of looking at causes of illness and disability. Alternative perspectives may include or exclude the fundamentals of the medical model, particularly the existence of pathogens. This does not necessarily deny the existence of pathogens, but makes their elimination unnecessary as they are not the prime cause of the disease process. Those who regard environmental factors or geogens as the ultimate determinants of health may or may not ascribe to the 'germ theory' of disease, but this would be irrelevant if the elimination of illness was seen to be governed by factors of more significance than the existence of pathogens. Other, non-pathogenic, factors which may be seen as a primary or secondary cause of illness, with or without the presence of pathogens, include divine intervention, gender, race, employment.

The importance to the individual of particular factors determines which model is adopted; the degree of importance given to that factor determines the extent to which other factors are excluded or included. An individual who believes that diseases are caused by pathogens can accept to a greater or lesser extent the influence of other factors, such as environment, income or social class. Accepting that exposure to pathogens is the single most important cause of disease denotes an adherence to the biomedical model. The degree of importance given to the other factors denotes whether the individual's perspective is of a simple or complex structure. The purer or

more simplistic a model adopted the more it will dominate all activities arising from the context in which the model is being used.

One of the consequences of the adoption of a particular model is an effect on resource allocation. It is clear that when a particular world view dominates a society to the extent that there are vested interests in perpetuating it - what Illich describes as hegemony - resources will be concentrated on those activities which uphold it. In health care this means the diversion of resources away from those professions or occupations which do not subscribe to the biomedical model. These are successfully marginalised and labelled alternative therapies or quackery - depending to what extent they explain their therapies in mainstream or biomedical terms.

Growing dissatisfaction with the biomedical model and its variants as an explanation for the experience of health, ill-health and disease has led to the development of alternative theories. The growth of a politicised group of disabled people seeking ways of taking control of their lives away from medicine led to the formulation of the social model of disability. The challenge that this has provided to rehabilitation professionals such as physiotherapists in particular has been invaluable in focussing attention on the paradigm of physiotherapy. How useful the social model turns out to be for the development of a theoretical base for physiotherapy is debatable as much work needs to be done before the model moves from its polemic base to a valid theory.

The holistic model on the other hand is one which has been picked up by medicine and distorted to fit political ends. The basic premise of the model - that parts only have meaning in relation to the whole - is ignored in most medical and rehabilitation service delivery. Yet holism is welcomed as a useful adjunct to modern health care. By absorbing it into the fold of acceptable medical theory its challenging effects can be diluted. The result has been the development of the concept of summative dualism and

a merging of this with concepts of holism. It is not evident from the literature that many health professionals distinguish between the two.

The social model of disability on the other hand tended to be met with overt hostility from doctors and rehabilitation professionals. Holism is welcomed, absorbed and modified to suit the aspirations of professional health workers; the social model is to a large extent marginalised as being irrelevant to medicine and health care. The one offers as much as threat to modern medicine as the other. Perhaps the difference is that the social model is being developed by the very people whom health care professionals need to keep in a subordinate role. Patients, including disabled people, need to accept theories developed by the dominant players in society, not start developing their own. Perhaps this is the ultimate irony - health care workers being challenged by the very people who are supposed to need them and who are daring to say that it is the doctors and physiotherapists who need the patients more than they are needed.

The acceptance of one model as being more relevant to an individual or a profession is linked to the perception of the world or *Weltanschauung* of that individual or profession. Individuals will bring their own world-view to a profession but will then spend the period of their training being socialised into the paradigm accepted, or commonly held, by that profession. The paradigm of a profession such as physiotherapy must be made up of the total of the paradigms held by the individuals in that profession. In a holistic model those paradigms together will make a whole greater than the sum of the individual parts.

6. DISCUSSION

This study originated from my personal experience as a clinical physiotherapist working with elderly people. I brought 12 years experience as a physiotherapist to the study and the data from that period, although not specifically captured and presented, informed the development of both the research questions and the methodology. As the study progressed the research questions changed in the light of the findings of each stage. Hand in hand with the development of research questions went the development of an appropriate methodology *(see fig 2 p3).*

The first stage of the study focused on the question of why the relationship between nurses and physiotherapists working with elderly people in some places was riddled with conflict . This idea of conflict between the two professions arose from personal experience and was confirmed by interviews conducted with a range of clinicians and managers involved in the care of elderly people. These interviews formed an early part of the study and are reported as stage 1 interviews (*p103*). These interviews both confirmed the legitimacy of the area of study, and provided pointers to the next stage.

In order to examine relationships between nurses and physiotherapists two sites were chosen for study and appropriate methods of data collection developed. These were semi-structured interviews *(reported as stage 2 interviews, p119)* and two areas of clinical work were chosen around which to question physiotherapists and nurses. These two areas of clinical work, pressure sores and incontinence, were chosen because they were areas in which I had developed interest and some expertise. They were also, and more importantly, areas in which nurses and physiotherapists had to co-operate if their individual interventions were to be effective. A review of physiotherapy literature in these two areas formed an early part of the study but was

later discarded as being a diversion from the main thrust of the thesis as this was developed.

Observation and interviews were chosen to collect data for this stage. Issues to do with participant and non-participant observation *(see p77)* led to an attempt to develop a tool which captured the interactions between a nurse and a physiotherapist caring for an individual but was non-intrusive. Diary sheets were chosen to try to record the communication that nurses and physiotherapists claimed was at the basis of good multi-professional delivery of care.

The piloting of the diary sheets led to an important breakthrough in my understanding of the direction of the study. The failure of the diary sheets to collect meaningful data was not of itself an issue. One important finding from the process of developing and piloting the diaries was that relationships between nurses and physiotherapists in this study were poor even where effort had been put into presenting relationships as good *(see p128)*.

The data for this study came from a range of sources *(see figure 2 p3)*. The interviews were a key part of the methodology. The first set of interviews carried out were interviews with key players or stakeholders *(stage 1 interviews)*. Two therapy managers, four nursing managers, one general manager, one senior physiotherapist and one senior nurse participated in these interviews.

A series of pilot interviews took place prior to the stage 2 interviews. These pilot interviews were held with four nurses and three physiotherapists. The data from these interviews was not analysed as their purpose was to develop and refine the

methodology; I needed to identify and learn how to carry out the type of interview most valuable for the study. The pilot interviews were invaluable in this process and taught me much about my own position within the research process.

The stage 2 interviews were semi-structured and were carried out with twenty two nursing and physiotherapy staff at two hospitals. At Hospital W three primary nurses, two associate nurses, two nursing assistants and five physiotherapists were interviewed. At Hospital N two ward sisters, two staff nurses, two nursing auxiliaries and four physiotherapists were interviewed. Data from these interviews was analysed at several stages and figure 2 *(p3)* provides a diagrammatic representation of the relationship between the data from all sources and the development of the theoretical framework.

Two particular stage 2 interviews provided clues to the direction the study needed to take to uncover the reason for these poor relationships between certain professionals. Initially these clues were provided by a physiotherapist and a nurse working on the same ward. The physiotherapist emphasised that her approach to working with elderly people was no different to her approach to working with any other age group. To her a knee was a knee, whether it belonged to a young or old person. She argued that knees warranted the same treatment and that this was dependant on the diagnosis rather than the person to whom the knee belonged. Working alongside this physiotherapist were nurses who had changed their practice to fit in with a move to primary nursing and to whom a medical diagnosis was not as important as a nursing diagnosis.

As part of the move to primary nursing these nurses had discussed the concepts that lay behind different models of nursing practice and had made a conscious shift away

from a curative or medical model. Significantly they had recognised the importance of involving groups other than nurses in this change. Domestic staff, porters and doctors had been invited to meetings at which the impact of primary nursing on their input and practice had been discussed. However, no-one had thought of involving the physiotherapists and the move to primary nursing was presented to them as a fait accompli. The physiotherapists were expected to change their practice to fit in with primary nursing without any discussion of its impact. This appeared to be both an ineffective way of managing change, and a denial of any importance or value of physiotherapy in the care of that ward's patients.

During the period I was undertaking these interviews a visit was arranged to Burford Hospital in Oxfordshire. This was the first British hospital in which primary nursing had been introduced. It had been the object of much research and regularly ran study days to explain what it was doing and why. The nurses at Hospital W invited me to attend this study day as I was a researcher and they thought I would be interested. However, they did not think it appropriate to invite any of the physiotherapists they actually worked with to attend with them. I was therefore the only non-nurse on this trip to Burford, and, as became apparent during the day, the first physiotherapist ever to visit. During the morning the primary nurse leading the day made several disparaging remarks about physiotherapy. She emphasised the poor working relationships between nurses and physiotherapists on the primary nursing wards and explained that this was due to the refusal of the physiotherapists to change their practice. I asked whether the physiotherapists had been involved in any of the meetings held about primary nursing but was told that no it had not been seen to be necessary. I managed to speak with one of the physiotherapists who worked on the ward and she said that relationships between the physiotherapy team and the nursing

staff were very poor and that there were times when the physiotherapists refused to go onto the ward because of this. Having discovered that I was a physiotherapist the primary nurse apologised for some of her less temperate remarks about my profession but stuck to her arguments that physiotherapy input was incompatible with primary nursing. She explained that physiotherapists were not prepared to change their practice to fit in with the philosophy that underpinned primary nursing.

This visit to Burford Hospital provided me with more evidence that the poor relationships I had uncovered in the two settings I was studying was not isolated but appeared to reflect a conflict between two professions. It also appeared that this was a conflict that was not going to be openly discussed. Several nursing articles on multi-disciplinary working emphasised the valuable contribution made by physiotherapy; indeed some of these articles were written by the very primary nurses at Burford who admitted privately that they did not value physiotherapy. No attempt was made to deceive the primary nurse at Burford about my identity but on speaking to her afterwards it was clear that it was only because she assumed that she was talking to a group of nurses that she had said what she really thought about physiotherapy. This indicated that the collusion that had been evident at Hospital N between the physiotherapist and nursing sister in covering up their poor relationship was part of a much wider collusion throughout the two professions.

Back in the setting (Hospital W) one interview with a primary nurse on the ward moved onto models of nursing practice fairly quickly. This was at a time (1987) when a lot of work was being published in the nursing literature on different models and the theories on which they were based, but there was little evidence that physiotherapists were having the same discussions. An examination of the nursing literature therefore

proved extremely valuable and led to a re-examination of the data from the fieldwork. In the interviews in the other setting (Hospital N) I found what appeared to be a difference in models being used as the basis for practice between the nurses and physiotherapists. In an extremely traditional ward setting where nurses saw physiotherapy as something 'done to the patients' there was a senior physiotherapist describing her work as being based on a holistic approach.

It was this difference in explanations of practice that led me to examine and reflect on the theoretical models presented in the medical literature. This formed the basis for the theoretical framework of the next part of the study. The data from the period of prior ethnography, the fieldwork findings, and the literature were analysed from the perspective of models of healthcare. What became apparent was that both within the profession of physiotherapy, and at its interfaces with other professions, a difference in the models used as the basis for practice could be an explanation for tension and conflict.

Within physiotherapy different models were being used in practice; a medical or curative model appeared appropriate in some settings such as sports physiotherapy, a more holistic approach in work based on client groups such as elderly care. Additionally physiotherapists who were using modalities such as acupuncture and reflexology were basing their explanations of what they were doing on traditional chinese medicine (TCM). The special interest group conferences provided a forum for an examination of the interfaces between various specialities within physiotherapy and data from these conferences and their reports supported the argument that different groups were using different theoretical models and that there was tension because of this.

Reflection on the different models being used in practice identified that both professions used a range of models depending on the personal beliefs of individuals and the influences to which they had been subject. The appropriateness of these models seemed to be be dependent on the setting and the client group. Models were therefore not profession specific but where different models were being used by different professions conflict was evident.

The examination of the interface between nursing and physiotherapy had uncovered issues about physiotherapy which were beginning to be addressed in the physiotherapy literature. Reflecting on how nurses saw physiotherapists and physiotherapy had led me to focus on trying to establish how physiotherapists saw themselves. I found a profession which did not articulate clearly what it had to offer and its value. It could be argued that my being a physiotherapist may have led to them assuming that they did not have to explain it to me, that I would understand and value it without them having to articulate it. However, the interviews were conducted in a way which minimised this possibility and every opportunity was provided for physiotherapists to justify what they were doing. These interviews were conducted 13 years ago and the developments in the profession, particularly the move to Higher Education, may have improved the ability of physiotherapists to articulate what they do.

The link between practice and theory appeared at this stage in the study to hold a key to discovering what physiotherapists were doing. Data from the fieldwork interviews had provided a series of clues that this link needed to be explored, but little evidence that physiotherapists in practice would provide the evidence through interviews or observation. The data that led to the analysis of a paradigm suitable for physiotherapy practice was provided therefore from other sources. One source was the tacit

knowledge I brought to the study from my period of prior ethnography as a physiotherapist *(see p69)*; another source was the ongoing involvement I had with the profession during the years of the study; a third was the literature in which the profession was beginning to discuss why it was doing what it was doing, and to question its dependence on the medical model.

Calls within the literature for the development of paradigms appropriate to physiotherapy practice led me to examine and reflect on the need to retain what was valuable about existing theoretical frameworks. Physiotherapy had made good use of the medical model and it appeared not to be ready to reject this totally in all settings. Certainly much physiotherapy education still relied on a mechanistic approach to the human body. However, other models were increasingly being used by physiotherapists to explain and justify their practice. What was needed was a framework which captured the range of models that physiotherapists were using and to tie it in to the work on the development of professions and the relationships between professionals.

A study which started as a quest to discover why physiotherapists and nurses did not always work well together developed into an examination of the practice of physiotherapy. Physiotherapy was studied within a framework determined by cultural, historical and theoretical influences. All these were examined during the course of the study and provided direction and substance. The outcome was an identification of factors which need to be taken into account by the profession of physiotherapy as it develops practice fit for a new era.

7. CONCLUSION

This thesis is an exploration of a profession through the stories told by its practitioners and by the profession itself, through its history, social context and view of itself. While working as a clinician I frequently asked questions about why things were the way they were and was eventually told very firmly that no-one else had the answers to these questions and that if I wanted them I would have to find them myself. The process I was told was called research.

> "Curiosity is one of the most important attributes of a successful fieldworker. The need to know why people do what they do - to understand where they came from and where they may be going, how one generation passes its values to another - is one of the inner drives necessary to unlock the mystery of social interaction." (Fetterman 1991 p88).

7.1 The Study

An emergent, naturalistic design was chosen, or at least discovered during the study when I became anxious that I did not have an answer to those people who kept asking me what method I was using. This type of methodology draws widely on socio-anthropological studies of societies and cultures, and was largely developed during the 1970s and 1980s. It was influenced by the development of feminist research where gender was no longer another variable to be controlled, but a valid stance from which to examine the human experience (Mies 1983). Naturalistic designs, or listening to the stories participants have to tell, whether in words or through observation, is widely used in educational research, research into the effectiveness and appropriateness of educational programmes or interventions. This all mirrored what I wanted to find out

about my own profession - physiotherapy - and its relationship with other players in the health care arena. My search for meanings rather than facts led me away from the classic experimental design; my belief that everyone's story has validity and that numbers do not necessarily make something more meaningful led me away from a quantitative design; and my belief that we all experience our own reality which can never be the same as anyone else's to a phenomenological approach.

> "...naturalism is the approach that, in contrast to positivism's scientific model, accords primacy to subjective experience, is pre-occupied by the multiplicity of perspectives, and is reluctant to aggregate data by quantification." (Fielding 1993 p147).

The choice of a naturalistic design enabled the study to authenticate the experience of the individual stories (Whyte 1984, Bergen 1993), to justify the position of the researcher within the study (Marshall 1981, Rowan 1981), and to allow for an eclectic and pragmatic approach to the development of a methodological and theoretical framework for the study (Parlett 1981).

The danger in choosing such a design, or in allowing it to develop throughout the study lies primarily in 'confirmability bias' (Edwards 1968 cited Miles and Hubermann 1994). There is inherent in this kind of work a temptation for emerging data which fits in well with earlier data to be used to make a stronger case than is actually warranted. In other words, if the data I was finding confirmed what I already thought I knew about the profession, its relationships with others and how it viewed itself then they may be used inappropriately and at the expense of data that did not fit my own view. As Miles and Hubermann (1994) put it *"Plausibility is the opiate of the intellectual"*.

In addition, the adoption of a subjective approach to the study inevitably means that

personal interpretation of data will lead to bias. This study is not replicable as carried out by another would develop differently, and even if carried out again by myself would be within a different timeframe, different context and different world to the one in which the existing study occurred. There can be no defence of this other than that the researcher makes the study what it is and whatever illumination occurs would not have occurred had the study never been carried out. No single piece of work can tell more than part of the story of physiotherapy but, fortunately, *'it is not necessary to know everything in order to understand something'*. (Geertz C 1973, cited Wolcott 1994).

The likely, inevitable even, impact of the researcher on the field is well documented:

> "You are likely ... to create social behaviour in others that would not have occurred ordinarily..... informants will often craft their responses to be amenable to the researcher and to protect their self-interest." (Miles and Hubermann 1994 p265).

However, the care with which the interviews in particular were constructed and carried out, and the sensitivity both to the likelihood of influencing the setting and the participants, to a large extent mitigate against this invalidating the data collected. The other strength of the design that would have helped in this was my position within the framework of the research study - not being a 'stranger to the field' and able to understand the context within which the fieldwork was being carried out.

In the end, the findings are not of fact but of meanings and as such the study can only be judged by the extent to which it has been successful in shedding some light on the practice, context and theory of physiotherapy.

> " Or, as the lion in Aesop said to the Man, '*There are many statues of men slaying lions, but if only the lions were sculptors, there might be a different set of statues.*' "
> (Tuckman 1981 cited Miles and Hubermann 1994 p265)."

Had this approach not been adopted then large amounts of data would have been lost to the study. The data from the period of prior ethnography provided context for the interpretation of the findings; the data that came from just one or two people moved the study forward but could not be validated through quantification; the data provided by the stories illuminated the study and led to the next stage; the flexibility to follow my interest led to new insights as did the freedom to use my own judgement about what I should do next and who I should speak to (Fetterman 1991); and finally, the use of a technique which was about getting people to describe their experience of events (Whyte 1984) led on to the question *And why?* which essentially formed the basis of the thesis.

Perhaps the biggest challenge of the methodological framework adopted in this study was its open-ended nature. The temptation was never to finish, to carry on finding out more about the area and never to draw a final conclusion. In Parlett's terms this is the very value of the approach taken; what could be seen as a weakness of the study, its open-ended nature, facilitated the emergence of new lines of enquiry as data was collected and analysed. (Parlett 1981).

A significant decision in the study was to study relevant history to contextualise the development of physiotherapy as a profession. Whyte (1984) and Crombie (1996) acknowledge the importance of this in claiming that any study of an organisation or community must be built on a firm historical basis and must incorporate historical data into its analysis. Crombie (1996) in particular stresses the importance of studying

history to understand disease and medicine. This decision to examine the history of the profession and the context within which physiotherapy developed opened up contextual areas such as the development of physiotherapy within a male-dominated, science worshipping, medical hegemony; the role of women in society throughout the development of organised medicine; and physiotherapy's emerging place within the framework provided by the growth of medicine.

Physiotherapy's relationship with science, medicine and in particular with the bio-medical model of health formed a key theme of the thesis. Its position as the dominant model in society, health care and physiotherapy was examined and the still current relevance of the mechanistic approach to the human body expounded by Descartes. This relationship gave rise to tensions that are evident in practice, research, education and management. These have been explored by providing snapshots of the profession at certain key times when tensions were evident in making decisions that shaped its future.

Such moments include the portentous decision of the 'founders' to accept medical domination, the struggle for the development of specialisms within the profession, and physiotherapy's pragmatism in dealing with new challenges by incorporating new modalities (latterly Swedish remedial exercises and Galvanism, more recently lasers and acupuncture).

The tension continues and is evident within the physiotherapy research community by the continuing debate over developing appropriate methodologies for physiotherapy research (Parry 1991 and 1997, Roberts 1992, French and Swain 1997, Newham 1997), in education by the continuing debate about the education for practice which is

acknowledged as being more geared towards hospital working (Potts 1996), and in management by the need to describe and quantify physiotherapy services in terms which are understood by those who ascribe to a medical model of care (Roberts 1990's personal experience).

The main findings from the study as a whole are that there is a range of models available and used by physiotherapists to explain their practice; those most commonly identified are the bio-medical model, the bio-psycho-social model or summative dualism, social and holism; the literature indicates that there is a poor understanding of the basis of these and their implications for physiotherapy practice; any potential tension generated by an examination of the assumptions of the models is resolved within the profession, as within medicine, by watering down these models to make them compatible with existing paradigms.

The rise of interest in alternative philosophical bases has been generated by two factors. One was the adoption by physiotherapists working without direct medical referral of a non-medical model of care. The need to articulate this led to attempts being made to fit it into a holistic framework, particularly by those groups of physiotherapists who identified themselves by client groups such as elderly people or children. Those working with physically disabled people picked up the social model and ignored the polemic argument about rehabilitation therapists being one of the problem disabled people faced. The other issue which is currently driving the development of alternative models is the adoption of modalities such as acupuncture and reflexology which clearly challenge the medical model's basis of treating disease. The extent to which the adoption of modalities based on an Eastern philosophy challenges the traditional basis of much existing practice should not be underestimated.

The mechanistic model of Descartes is still the key influence in physiotherapy and continues to underpin much practice. Physiotherapy cannot sit in isolation from the rest of health care and society and is bound by the continuing dominance of Cartesian reductionism.

> "It remains true to say that our own world-view is heavily influenced by the mechanistic notion of the bête-machine and all its implications for biology and medicine. In this sense, the mechanistic physiology of Descartes and others can be seen as the origin of the modern biomedical sciences." (Henry 1997 p69)

The search for new paradigms, new ways of thinking, new ways of explaining physiotherapy, has been identified particularly within the last decade. (Tyni-Lenné 1989, Parry 1997). Kuhn (1962) identified moments within the development of a discipline that force the pace of change.

> "...when...(a) profession can no longer evade anomalies that subvert the existing tradition of scientific practice - then begin the extraordinary investigations that lead the profession at last to a new set of commitments, a new basis for the practice of science." (Kuhn 1962 p35).

Parry (1997) has argued that physiotherapy is in the process of proceeding through Kuhn's model of scientific change but is multi-paradigmatic and will gain little by turning its back on anything. This is the pragmatic model that is so evident in the way physiotherapy has developed its practice and its knowledge base. However, there is clearly a need to choose wisely in the search for meanings behind what physiotherapists do. The pragmatism that led to alliances with contemporary dominant models have served the profession well at times, but have also restricted its journey towards true professional autonomy. Parry (1997) talks of the 'joy' of pragmatism in

research and practice in accepting that:

> "all knowledge is hypothetical and subject to change, modification and evolution; that knowledge in physiotherapy has no permanent status, but enjoys current acceptance." (Parry 1997 p428)

The strength of this argument lies in its acceptance of the reality of physiotherapists using whatever is fashionable in theoretical concepts to justify physiotherapy practice; physiotherapists can happily go on doing what they have always done and just adapt a current theory to explain why it is effective.

The weakness of it is that is makes physiotherapy a profession that has not taken ownership of a knowledge base that it has developed and called its own. It describes a profession that waits to be challenged and then searches for an acceptable piece of received wisdom to explain what it is doing. A more assertive, independent and proactive approach to developing an identifiable knowledge base can only serve the profession well and has been called for by Parry herself (1991, 1995 and 1997; Richardson 1993; Roberts 1994).

There is then a need to respond to the calls for the development of a new paradigm for physiotherapy, with the pragmatism of a profession which is essentially practice-based, and without rejecting what has served us well and can be used as a springboard for such a development (Parry 1997). This study has identified those components, both contextual and theoretical which I believe must be incorporated into the development of such a new paradigm for physiotherapy.

7.2 Strong professional identity

The discipline of physiotherapy needs to be able to articulate what it is doing, in it own

terms, if it is to justify its claim to be a profession. (Friedson 1970a; Larkin 1983; Miles-Tapping 1985; Jones 1991; Richardson 1992; Parry 1995). There was evidence from the fieldwork that physiotherapists are not confident about articulating what they do. However this data was collected more than a decade ago and from a very limited group within one area of the practice of physiotherapy. This finding cannot therefore be generalised or transposed into contemporary accounts of the profession. However it echoes, and reinforces, calls for the profession to be able and ready to do just that in the face of continuing challenges (Grant 1995, Potts 1996, Parry 1997).

Attempts to produce a definition of physiotherapy have yet to come up with one that has stood the test of time. This is reflected in the way these definitions have changed over the years to reflect both the changes in the context of the provision of physiotherapy and the aspirations of its practitioners. This may reflect the changing face of a profession that is above all pragmatic ready to respond to the changes and challenges that confront it, or it may reflect a profession that still does not really know what it is within its framework that is unique and worthy of being defined. (See Appendix G for definitions of physiotherapy 1974-1996).

There has yet to be written a definition that is flexible enough to encompass all that physiotherapy is and does, while being focused enough to identify the unique package that is physiotherapy and that clearly identifies us as a separate profession. It may be that such a definition will never be more than a marketing tool, and will never be able to fulfil the aspirations of a disparate group of professionals arguing from the perspectives of different needs - educationalists, researchers, practitioners, managers, commissioners and providers of physiotherapy. However being able to articulate what distinguishes the practice of musculo-skeletal physiotherapy from say the practice of

musculo-skeletal medicine must be a step towards identifying the springboard from which the profession can move towards identifying its own knowledge base.

7.3 Relevant knowledge base

An identifiable and articulated knowledge base is essential to support claims that physiotherapy is a true profession. Physiotherapists have traditionally relied upon theory and knowledge developed in other disciplines such medicine, physiology, and psychology, as befits a professional supplementary or even subordinate to medicine. Work is now being done in areas which are not coterminous with that done by other disciplines and is being done by physiotherapists within a physiotherapy framework. Examples of this are the work physiotherapists are doing in developing models of pain management (Gifford 1998), and in developing models for clinical reasoning (Jones 1992 and 1995). These models build on, and make use of, knowledge gained and used within other disciplines but are grounded in physiotherapy practice. We are now seeing the development of theoretical models which are physiotherapeutic models linking theory and practice and which make sense only within the framework of physiotherapy practice. They are models which may be recognised as valid by others but would not form the basis for others' practice. They question is whether they are more than just descriptive models and have been developed into theoretical models which make them a sound base for further theoretical work.

As a profession we need to legitimise our own knowledge of what works and thereby lay claim to our own knowledge. Much may be 'borrowed' from other disciplines but the package is physiotherapy - what we accept, what we reject, how we make use of, and apply that theory is what distinguishes us from other disciplines, and we need to claim the work, practical and theoretical that is being done within framework of

physiotherapy as physiotherapy knowledge.

7.4 Existing models

Bio-medical model

Western medicine is based on the bio-medical model and seeks to identify and treat specific diseases. The identification of a causal agent has been a driving force behind the development of the knowledge and power base that is dominant in contemporary health care in western society. The germ theory is still the basis for much of what is prescribed and practised, as new projects are undertaken and new knowledge uncovered its acceptability and usefulness is still determined by the extent to which it can be used to identify the cause of disease and illness. The human genome project is one such example where the prevailing popular interpretation of cause and effect has led to claims of the discovery of genes which cause homosexuality, aggression in women, and poor spatial awareness - all of which have been at least temporarily defined as illnesses amenable to treatment now that the causal agent has supposedly been identified.

The bio-medical model has served society, medicine and physiotherapy well in providing a framework for the development of an understanding about the human body and its frailties. However it is not the all encompassing model claimed by the medical profession and its usefulness is largely contextual. Its appropriateness to physiotherapy practice has been challenged (Stachura 1994; Roberts 1994; Parry 1997) but as yet there is little evidence that it is about to be discarded. Indeed Roberts (1994) argued that it is too fundamental to the practice of physiotherapy to be discarded. It serves as a useful model particularly for those practising musculo-skeletal physiotherapy, working closely with doctors in acute branches of medicine, and allows physiotherapists to claim a legitimate place within the wider medical arena.

Whatever the new paradigm is that physiotherapy adopts it will, I believe, continue to make use of the medical model, particularly when working in contexts and with colleagues and patients, for whom this is the most appropriate and relevant paradigm. The challenge is not to see it as an either or situation but to absorb it into a new way of thinking and articulating what physiotherapists do.

Holistic model

Holism, as Smuts described it, incorporates both the sense of wholeness and of patterns. He saw the reality of the world not as matter, but as arrangements, or flexible changing patterns. (Smuts 1929 cited Smuts 1952). Eastern medicine is similarly based on discovering patterns, on restoring balance and harmony There are strong echoes of Smuts' holism in descriptions of Traditional Chinese Medicine (TCM):

> "(it) demands the artistic sensitivity of synthetic logic - always aware that the whole defines the parts and that the pattern may transform the significance of any one measurement within it..." (Kaptchuk 1983 p19).

> "The Chinese method is thus holistic, based on the idea that no single part can be understood except in its relation to the whole. A symptom, therefore is not traced back to a cause, but is looked at as part of a totality. (Kaptchuk 1983 p7).

Another strong link between holism and TCM is the emphasis on movement and change. The Chinese assume that the universe is continuously changing and that its movement is the result of 'an inner dynamic of cyclical patterns'. (Kaptchuk 1983). Smuts talked about the whole not just being greater than the sum of its parts but producing a force that allowed progress to be made and the 'additional building of creation'. (Smuts 1929, cited Smuts 1952). Continual change and continual movement, are therefore integral to both Smut's holism and TCM.

Acupuncture and reflexology are modalities which physiotherapists have incorporated into their mainstream practice over the past two decades. They are used because they work and because they have links with the existing paradigm of physiotherapy - they are physical interventions not linked with surgery or drugs but with enhancing the body's ability to heal itself. The drive to justify them in western scientific terms has led to physiotherapists articulating two very different explanations - one based on TCM and one based on western scientific thought. (Ellis 1994; Filshie and White 1998). Those training courses for physiotherapists in acupuncture which are recognised by the Acupuncture Association of Chartered Physiotherapists (the majority) provide both TCM and western explanations for the effectiveness of the modality.

The choice of the model the therapist then offers appears to depend on the world-view of the particular physiotherapist offering the explanation and their judgement of the world-view of the recipient of the information. Physiotherapists seem less interested in which explanation as to why these modalities work is true and more interested in the fact that they work. Evidence again of the pragmatic nature of physiotherapy.

So we have on offer an theoretical model - holism - that covers the desire to work to more than the mechanistic approach of the bio-medical model, has clear links with the currently fashionable TCM approach, and which emphasises change and movement. Physiotherapists need to work with this model to identify how their practice is being affected by the adoption of it and to what extent it is really used in a way that is more than summative dualism.

Social model

This is essentially a polemic model which is currently being used by the disability movement as a basis for developing a civil rights movement (Roberts 1994; French 1994) . This is not a model that can be picked up and used as it stands by physiotherapists as it writes rehabilitation professionals out of the picture completely (Roberts 1994). However it does have a story to tell that the profession must listen to (French 1992). There are challenges for the profession and for individual physiotherapists over, for example, the issue of disabled people training as health professionals; the challenge of not locating the source of the problem always within the patient, and the need to resist treating everyone encountered in practice as a patient. The impact that this has had on physiotherapy along with other health services is evident in the search for acceptable term. Disabled people object to the term patient being applied when they are not ill, and the profession has responded by using other terms - client, service user, customer, person - all of which are at times appropriate and at times inappropriate. The use of such terms appear to be reflecting the appropriateness of different models.

There has also been a strong influence on the development of appropriate research methodologies which take into account the experience of disabled people themselves and which rejects the positive approach to research. The recognition of the expertise that disabled people have about themselves and their experience has been manifest in disabled people such as French, Morris and Oliver undertaking research themselves, not being the subject of other people's study.

7.5 New Relationships

New relationship with patients

This is an issue in which context is extremely influential. Consultants held the power base within health care for many decades. The health care reforms of the late 1980's and 1990's shifted a lot of that power into the hands of General Practitioners. Within medicine this may be a revolution but it still left medical doctors in the driving seat for the development and delivery of health care. Doctors work to and want from others primarily a curative model. Contextualisation in primary care affords possibilities for both the development of a highly medical model and a more holistic approach. The move to primary care has led to physiotherapy out-patient services (largely musculo-skeletal physiotherapy) moving out of large district general hospitals into the local GP surgery or health centre. GPs purchased (under fund-holding) or commission a curative model of physiotherapy. What GPs want is a quick fix for the painful backs and necks they see in their surgeries. Physiotherapists have responded by providing this but, pragmatic as ever, are adapting new modalities such as acupuncture to fit in with their musulo-skeletal work. Working therefore in a setting which demands adherence to the medical model they are nevertheless using modalities which arose out of TCM and providing scientifically plausible explanations for what they are doing (Ellis 1994, Michie, Drew and Langdon 1996).

The move out of acute hospital settings and the range of settings apart from GP's surgeries which are not accessible to physiotherapists, such as patients' homes, community centres, leisure centres, have also meant that physiotherapists have had to renegotiate their relationship with patients. The physiotherapist may be the expert but may now be on the patient's territory. The knowledge and perspective of the

individual - whether patient, customer or client - needs to be taken into account in a way that can be largely ignored in hospital. Again, it is context which is providing the challenge for physiotherapy and will continue to do so, demanding a paradigm that involves continuous change.

New relationship with other health professionals

This is where this study began. The starting point was the experience of variable relationships with nurses. This was the discipline that physiotherapists working with elderly people in hospitals had more contact with than any other. The issues that arose from the fieldwork gave rise to other questions that needed exploring and led on to an examination of theoretical models of physiotherapy and the finding that the practical models that are used in everyday nursing and physiotherapy practice give rise to tension and conflict when there is a mismatch.

Team working has been a key issue within health care. The existence of different disciplines, different professions, in health care may have arisen from the drive towards specialisation and the relentless force of reductionism. This would have led to professions each grabbing a bit of the body or a bit of practice to justify their continued existence. However, the evidence from the examination of the development of physiotherapy leads to a view that there were disparate groups working independently within society, all attempting to affect people's health. As medicine established its hegemony these groups got pulled in and negotiated their relationship with medicine in different ways.

However it arose, the fact is that health care is largely delivered by more than one profession and that there is a push for that delivery to be coordinated to ensure the

patient gets the best possible package (DoH 1999). Potts (1996) identified several forces that are likely to influence how this happens, some political, some practical and essentially for the benefit of the person in need of health care. A naïve view is that this happens in hospital with a doctor in charge and everyone under one roof and working under one system with good communication in place. However it is clear, from personal experience, from the fieldwork and from recent government calls for more work in this area, that being in close proximity, having the means to communicate well and co-ordinate care does not mean it happens. Care can and will be provided by individual professionals irrespective of what anyone else is doing.

The move to community based health care has made the issue of communication and coordination of care physically more difficult. The model of one physiotherapist working in each GP practice has not happened (DaSilva 1990). In the 1990's and early 2000's physiotherapists are more likely to be working across several practices, or in the private sector with contracts with several GPs. They will not have access to the same facilities and so communication may suffer. However, this challenge may have focused minds on the need therefore to develop systems that allow for better team working. The evidence from the fieldwork did indicate that where problems between professional groups had been identified and acknowledged effort was more likely to be put into finding ways of improving things. Again, this was evidence from one setting, at one particular time, but serves as a useful indicator that communication does depend on a recognition of the importance of and a willingness to communicate.

The move to primary care therefore and the growth of the independent sector in physiotherapy means that coordination of care delivery is likely to be more difficult, but paradoxically may be identified as a potential problem with resources being

directed towards solving it.

Potts (1996) has recognised the possibility of this challenge being met by the merging of professions; whether individual professional groups will manage to resist this remains to be seen but whatever happens physiotherapists have to absorb the culture of inter-disciplinary care giving into a new paradigm (Smith, Roberts and Balmer 2000; Roberts and Smith 2000).

New relationship with medicine

I would argue that there is a clear need to redefine and renegotiate the relationship physiotherapy has with medicine. There has been over the years a gradual move away from the totally dependent model negotiated towards the end of the last century. Physiotherapists now have the right to practise autonomously as first contact practitioners. The profession is beginning to develop its own knowledge base, and is taking up the challenge of research to demonstrate its effectiveness. The move to higher education has been a key factor in providing physiotherapists with the skills and maturity to do this. However a key issue relates to the theoretical framework within which physiotherapists undertake the research and lays claim to a knowledge base. While that theoretical framework is based largely on the bio-medical model, or variations on it such as summative dualism, then the knowledge base will serve to reinforce the dependent relationship physiotherapy has with medicine. To move to an independent stance, and ultimately to interdependence in those areas where this would be more appropriate, physiotherapy research needs to be based on a theoretical framework that takes account of, indeed is built on, the differences between physiotherapy and medicine, rather than the similarities.

While there was a great move to professional autonomy in the 1970s and 1980s, the shift to community, often GP based practice posed yet another challenge for physiotherapy. Issues over medical hegemony are still largely unresolved and the move to Primary Care Groups, with GPs being guaranteed the Chair of these groups and a majority of the voting membership, will not challenge the dominance of medicine within health care. Indeed it could be argued that the move to take power out of the hands of hospital based consultants, and give it to GPs has given back control of physiotherapy practice to the medical profession. Under fundholding arrangements in the early and mid 1990s GPs were purchasing physiotherapy; with the change to PCGs GPs will be commissioning physiotherapy. In both these models GPs will be deciding what they want and therefore what physiotherapy is to be practised within that framework. As they largely, by definition, work to a medical, curative model this poses a big challenge to the profession. Having lost the right to control physiotherapy through an exclusively medical referral system, doctors have regained control through financial measures.

One of the significant moves that the profession has made in recent years is the move away from considering the NHS as the normal employer of most physiotherapists for most of their professional lives. There has been a rapid growth in the number of physiotherapists working in non-NHS settings with 35% of new graduates not intending to work in the NHS for longer than three years and 52% not expecting to spend the majority of their working life in NHS employment. (NHS 1999). There is no firm evidence as to why physiotherapists are abandoning their traditional employer in such large numbers. Pay is clearly an issue but there is some anecdotal evidence that loss of professional autonomy within the NHS is a factor. (Roberts 1999 personal communication). It may be that the medical model is not so dominant in non-NHS

sectors and that physiotherapy is freer therefore to develop non medically determined practice.

Whether the future of physiotherapy lies within the NHS or not will influence how the profession continues to develop. The formation, development and reformation of the NHS provided perhaps the most important contextualisation for the development of the profession of physiotherapy. Physiotherapy existed however before the formation of the NHS in 1948, and has had a significant private sector ever since. It may be that the focus shifts away from NHS employment, to the detriment of the NHS, to independent practice; whatever happens it is the determination with which physiotherapists continue to pursue true clinical autonomy, based on physiotherapy knowledge, that will determine to what extent physiotherapy attains full professional status.

7.6 A Paradigm Shift

Kuhn (1962) is very clear in his message that a true scientific revolution involves throwing off the old to take on the new:

> "Each (scientific revolution) necessitated the community's rejection of one time-honoured scientific theory in favour of another incompatible with it.....a new theory, however special its range of applications, is seldom or never just an increment to what is already known. Its assimilation requires the reconstruction of prior theory and the re-evaluation of prior fact...." (Kuhn 1962 p6).

Kuhn discusses the way history is written, re-written and adapted with hindsight to provide what appears to be an incremental growth in the development of a knowledge base. The reality is different, with the past needing to be adjusted to fit in with the present.

It is difficult to see how physiotherapy can reject the bio-medical model upon which so

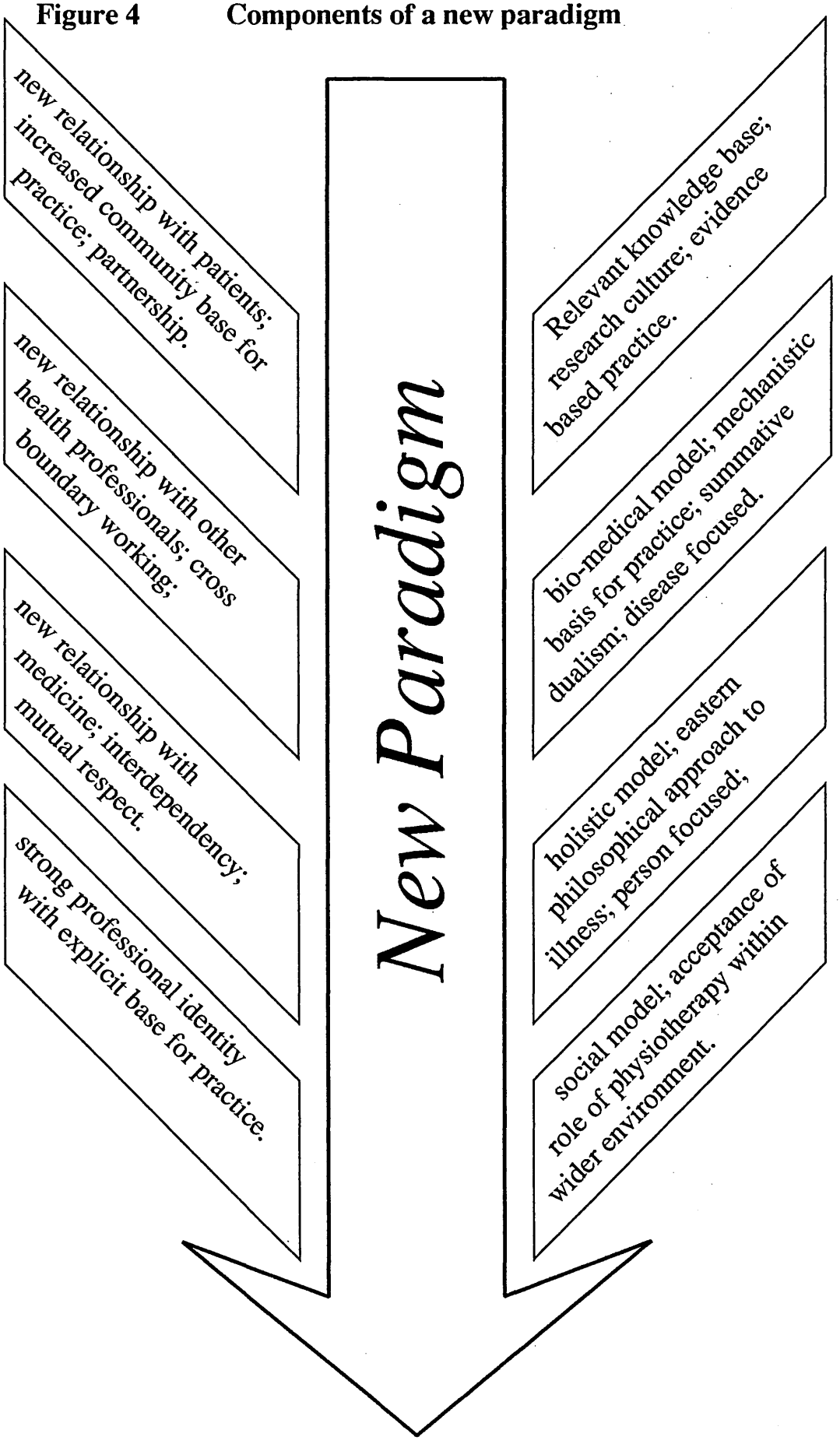
much of its practice is based, and which is still the predominant paradigm for most health care. However, it may be that holism will provide a way of building on existing knowledge and moving forward. Traditional Chinese Medicine is attractive because of its very practical approach to treating people and symptoms and offers a comfortable paradigm based on the restoration of harmony; the bio-medical model has a key element which is about homoeostasis - a restoration of normal function, a continual force to return things to what they were. Both systems are therefore based on concepts of restoration, of returning things to normal, to a state that existed before the person became ill.

What holism offers over and above these two models is the element of incremental change found in Smuts' claim that the whole generates more force that the sum of the parts can provide, and that force is a force for change, movement and advance. Holism is about change, about moving on and about continual creation, not about returning things to a previous state.

This element of holism has largely been lost from contemporary accounts of the model. The literature concentrates on those elements which essentially comprise summative dualism - adding together our knowledge about the parts of the person and coming up with something that is more than just the bio-medical model. Most authors, within physiotherapy and in the larger health care field, ignore concept of change. Holism has been moulded to fit in with concepts of restoration and homoeostasis rather than its original meaning of movement and change.

Physiotherapists have a pragmatic approach to practice. They adopt and adapt old and new modalities as a base for their practice; they continue to adopt and adapt new

Figure 4 Components of a new paradigm



models as a base for a physiotherapy paradigm. The knowledge base is drawn from a range of sources and adapted to fit in with physiotherapy practice.

The challenge for the future is to expound a theoretical framework of physiotherapy which is a redefinition of the relationship between the medical model and holism, and incorporates elements of the social and TCM models. Rather than seeing holism and the bio-medical model as two incompatible models between which physiotherapists need to choose, treating either the person or the disease, we need to use the holistic model as the blueprint for developing a physiotherapy paradigm. We need to take the elements, the parts of the models we are currently using, add them together and allow the wholeness of physiotherapy to generate the force that will move both us and health care forward (Figure 4).

The concepts that physiotherapists are currently using to define, justify and provide their practice can be added together into a theoretical framework that comprises all that physiotherapists do, and believe. A summation of the world-views and practices of both individuals and individual parts of the profession, will produce something that is greater than the sum of its parts. Smuts identified incremental change as the key mechanism for improvement; rather than Kuhn's overthrowing of the old order, or the stasis of models based on balance, holism provides a driver for movement and change, newness and renewal.

It is the wholeness of physiotherapy that will move knowledge and practice on. A holistic framework is one within which individual components can exist and can amount to more than if they were separate components. Physiotherapy practice provides the glue that binds the bits, adds meaning and creates something new,

greater, and better.

Perhaps the context for this paradigm shift can be provided by a country which has at long last emerged out of the domination of white colonialism into a new future; the search for patterns and meanings in the chaos of post-Boer war South Africa can provide the impetus for the search for patterns and meanings in the practice of a profession which will one day emerge from the domination of medical hegemony.

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Appendix A

Letters agreeing co-operation with study

Chairman — Mr. Robert B. Robinson T.D., J.P.

DISTRICT GENERAL MANAGER
C. J. M. NEWTON, A.H.A.

WHITWORTH HOSPITAL
330 BAKEWELL ROAD
DARLEY DALE
MATLOCK DE4 2JD
Telephone: Matlock (0629) 3846
Ext:

Please ask for:

Your Ref.

Our Ref.

5th March 1987

Dear Mrs. Roberts,

Thank you for your letter of 2nd March asking if we will participate in your studies of inter-disciplinary care of elderly patients.

We shall be very pleased to participate.

Yours sincerely,

Anne Sarsoon

Nursing Officer

Mrs. Pennie Roberts,
DHSS Remedial Therapy Research Fellow,
Sheffield City Polytechnic,
36 Collegiate Crescent,
SHEFFIELD S10 2BP.

SHEFFIELD AREA HEALTH AUTHORITY (TEACHING)

N.E.8

Date 12th May 1987

MEMORANDUM

Your Ref.

Our Ref: PT:ECB:SMB

From: Mrs E C Brewer
Superintendent Physiotherapist
Nether Edge Hospital
Osborne Road
Sheffield
S11 9EL

To: Department of Health Studies
Sheffield City Polytechnic
36 Collegiate Crescent
Sheffield
S10 2BP

Mrs Penny Roberts has approached this department requesting our co-operation in her research project. We shall be pleased to offer our support in this matter.

Elizabeth C. Brewer.

Appendix B

Example of notes from a field visit

13.10.88

visit to NEH to see Jean [redacted].

Jean very "up in the air" (her words) as she had been told the previous evening by Dr [redacted] that there was a possibility they would lose the hydrotherapy treatment room on Cas 2.

Very significant for treatment – why they are losing it now? – unit manager ex-nurse

Jean thinks this is significant – ready to listen to nurses + understands their needs but know little about physio needs etc.

Jean had just been to see Liz [redacted] – her manager and they were writing re no. of uses the treatment room was put to – teaching lifting + handling to nurses, treating staff, treating doctors. 'supervision' of each others' patients physio students – able to observe + be supervised ..

As well as ideal treatment area for

patients. close to wards. aids communication
betwn nurses + physios. less time wasted
etching patients. if one patient not ready
r treatment then can take another along.
nurses have easy access to patients eg. for
edication, toileting regimes etc. nurses watch
at is going on easily in physio (ie what
e nurses were asking for at Whitworth!)
Under new system physios from Law would
we to share [redacted] Out patient dept in
ndhurst - would mean portering service -
ver adequate or satisfactory - lot of wasted
me waiting for patients or would have to
portering self. Make more difficulties
r nurses if having to get patients ready
go to physio. Physio done well away
om block - not accessible readily to nurses.

Less communication btwn nurses + physios
longer 'turn around' time for discharges as less
physio input.
Jean seems resigned to inevitability of losing
m - feels the 'hints' mean that a decision
s already been taken. Very puzzled over
y Dr Cox has agreed to this. Argument
that 4 extra acute beds are needed
ver the winter months - but Jean says
ey will lose the benefit of these extra
eds as discharges will be delayed.

"I feel as if we might as well
not bother to come on here and
do anything if they take that
room away."

Was annoyed as well that she had been
sked to fill in the previous day quite
a complex form asking for details of her
pirements and how they were being

not in terms of space, equipment etc.
we had made suggestions over new curtains,
-organisation of room etc. Now she feels
it was a 'cov' as the decision had
already been made over her losing
cat room.

> "I might just as well have written
> piss-off across the form for
> all the notice they'll take when
> they get it. They're asking
> me to fill it in and before they've
> even got it back they've
> deciding to take the room
> away."

Arranged three interviews with her + 2 staff
- Tricia [redacted] next Thursday - then Ann [redacted]
+ Jean to be arranged next thurs.

As I left the ward Jean was pointing
out how depressing the lobby at the top of
the stairs is and said she is always
complaining eg. about the X-ray machine
and the sacks of rubbish by the lift (4 at
the time) and the general air of neglect

Then she took me onto Cov 3 and

ointed out the day room which the
id was grossly under-used. At that time
.30 am) there was one man and a
umen sitting in it. Jean said that was
a usual number and yet money had
een spent on a 3 piece suite and carpet
r one end - JP said appalling chairs - no
ood for patients to sit in - bad enough for
taff & relatives as no support for backs -
difficult to get out of.

Appendix C

Example of, and instructions for, filling in diary sheet

INSTRUCTIONS FOR FILLING I

Fill in daily - either during your working day at convenient intervals, or at the end of the day.

Keep notes - keep brief notes of contacts made in your pocket notebook if you are unable to fill in the sheet immediately. Record the time of the contact as a minumum with a few notes.

Record ALL Contacts - however brief or casual about the selected patient, including those where you have left a message with someone else for passing on, and those where you have received a message from a third party.

Use a new diary sheet - for each contact recorded, however briefly you have written about it.
please send in a blank sheet for days not worked, stating - off duty, off sick, holiday etc.
" " " " " " " when no contacts made - stating 'no contacts made'.

RECORD ON THE DIARY SHEETS THE FOLLOWING INFORMATION

DATE: at top left of each sheet.

WHEN: please record the time at which the contact took place.

WHERE: please record where the contact took place, eg. Sister's office, the patient's bedside, ward corridor, physio department, over the telephone, etc.

WHAT TYPE: was the encounter pre-arranged or by chance, regular or specially arranged, who else was present, eg. the patient, doctor, other nursing staff, OT etc. please specify.

WHY: please give as many details as possible about the purpose of the contact - was it to ask for information, to pass information on, to comment on the patient's condition, progress, etc. was it to ask for or give advice on the patient's management, was it being made on someone else's behalf eg. were you passing on information from the doctor or another person? Was the contact useful, informative? Do you have any comments to make about its value?

WHO: who initiated the contact? eg. who approached who? If the contact was a regular event can you indicate whose idea it was to have these regular contacts?

e comp e e , p ease p ace in the dated envelope provided, seal and post.

If you have any problems or queries please do not hesitate to contact me on:

SHEFFIELD	665274 ext 3233	(work)
DRONFIELD	417242	(home)

ALL INFORMATION WILL BE TREATED AS STRICTLY CONFIDENTIAL

SHIFT.....
(time shift started
and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated

Appendix D

Examples of completed diary sheets

WHITWORTH

No. 4

RECORD OF CONTACTS MADE re PATIENT X

WHEN Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated
00	NURSES STATION	FACE TO FACE VERBAL BY CHANCE (BUT A TIME WHEN I WOULD NORMALLY EXPECT TO MAKE CONTACT.)	DISCUSS SUITABILITY OF PATIENT X FOR TRIAL WE AGREED THAT HE WAS SUITABLE BECAUSE HE HAD MOBILITY & SKIN PROBLEMS SO WE WOULD NEED TO CO-ORDINATE CARE.	A.R.
00	CASE CONFERENCE	BRIEF OUTLINE BY P.C.N. & DR. ON PATIENTS CONDITION	FOR THE INFORMATION OF THE TEAM.	

No. 4

RECORD OF CONTACTS MADE re PATIENT X

WHEN Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated
00	WARD	CONTACT WITH ASSOCIATE NURSE BECAUSE PRIMARY NURSE NOT ON DUTY THAT DAY	TO ARRANGE A SUITABLE TIME FOR PHYSIO TREATMENT TO FIT IN WITH PATIENTS OTHER NEEDS	A.R.
.15	PATIENTS BEDSIDE	ASSOCIATE NURSE TO HELP WITH TREATMENT	HELP & ADVICE NEEDED ON BEST WAY TO HANDLE PATIENT X ONTO TILT TABLE IN VIEW OF SKIN PROBLEMS.	A.R.

No. 4

RECORD OF CONTACTS MADE re PATIENT X

WHEN Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated
00	NURSES STATION	FACE TO FACE WITH PRIMARY NURSE CHECKING THAT PATIENTS PROGRESS ON PREVIOUS DAY WAS KNOWN TO P.N.	TO DISCUSS SUITABLE TIME FOR TODAYS TREATMENT	MYSELF

DATE .....

No. 4

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated
00	OVER PHONE	ARRANGE WITH PCN. 2.30 TREATMENT WITH KROMATER NURSE TO TAKE DOWN DRESSING & HAVE PATIENT READY	TO ARRANGE TO HAVE PT. READY SO I CAN TREAT WITHOUT DELAY OR INCONVENIENCE TO PATIENT.	EAR
00	IN QUIET ROOM	FACE TO FACE	TO SAY I HAD FINISHED Rx & PATIENT READY TO HAVE DRESSINGS	EAR.

DATE [illegible]

No. 4

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated
1.30	NURSES STATION	FACE TO FACE	TO ARRANGE U.V.L. TREATMENT AT 12.00	EAR
2.30	WARD	FACE TO FACE ~~TO~~	TO LET P.C.N. KNOW THAT Rx WAS FINISHED & PT. READY FOR DRESSING	EAR

DATE ...9...9.....

No. 4

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated
30	PHYSIO/WARD	PHONE CALL	PHYSIO HELPER TO PCN. TO ARRANGE 2.30 TREATMENT	EAK
~~30~~ 40	NURSES STATION	FACE TO FACE	TO DISCUSS PATIENTS CHANGE IN CONDITION	EAK

DATE ....1....1.....

No. 4

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiated
1.30	QUIET ROOM ON WARD	FACE TO FACE	TO DISCUSS TREATMENT & CHECK ON PATIENTS CONDITION	EAR.
.30	PATIENTS BEDSIDE	FACE TO FACE	ASSIST WITH TRANSFER ON TO TILT TABLE	EAR
.00	WARD PASSAGE	FACE TO FACE	ASK NURSE TO TAKE PATIENT OFF TILT TABLE ONTO BED	EAR.

WHITWORTH

SHIFT 0800 - 1600 Hrs.
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
11-30 Am.	The 'Quiet' room, where the MDT meeting is held.	A 'Regular' encounter in the form of the Tuesday MDT meeting. Present 3 Primary Nurses. The Physiotherapist. 3 G.Ps. The Occupational Therapist. The Social Worker. The Senior Nurse (chairperson) The Consultant Gerontrician.	The purpose of this encounter was to share information within the membership of the Multi disciplinary team. (MDT). Our patient being a new admission, it fell to me to introduce him at the meeting and to pass on the information I had collected at admission. When it came to discuss specific point, regarding his Paraplegic condition, I asked Physiotherapist to comment. It was here that she first made some mention of the passive, stretching exercises that she wished the Nurses to	The Tuesday meeting was agreed upon the M.D.T. seemed to the most each time everybody com to be able get together.

SHIFT. 0800 - 1600
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
~ 1430Hrs	Nurses station.	Chance encounter. Myself & Ann Reid.	We first discussed the appropriateness of using our newly admitted patient for the purposes of their project.	Physiothe

SHIFT 0800 - 16:00 Hrs.
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
9:00 to 10:00 AM	One of the Five bedded bays on the Ward by our Patient's bed.	A 'Chance' encounter. Present: A[illegible] Myself. The Patient.	I approach the Physiotherapist whilst she was working with our Patient so that I could observe her demonstrating the passive exercises she felt appropriate. During this time, we both of us talked briefly with the patient to ascertain additional information regarding the history of condition.	Physiothera[illegible] initiated [illegible] demonstra[illegible]

SHIFT. 1230 - 2030 Hrs
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
~ 15-00 Hrs	The Nurse Station.	'Chance' encounter.	Physiotherapist informed me that she had had, our Patient on the 'tilt table' as a part of his treatment and that he had enjoyed the sensation of being upright.	Physiotherap initiated.

SHIFT. 0800 - 1600 HRS.
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
14-30 HRS	5 bedded bay by our patient's bed.	Pre-arranged encounter. Present Myself. Physiotherapist. The patient.	I had arranged to see how our patient together would he was on the 'Tilt table.' [redacted] was able to briefly point out features of the device and we were both able to elicit the comments of our patient his feelings regarding this aspect of his treatment.	I initiated meeting.

SHIFT 0800 - 1600 Hrs.
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
11¼ - 15 Hrs	By our Patient's bed.	A 'chance' encounter. Present Myself. Ann Reid. Patient & his wife.	She briefly 'popped' in to inform me that she wished to treat the patient at 1530 hours.	A[redacted]

No.

SHIFT 1230-20-30 HRS
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
13-30 Hrs	Nurses station.	Chance encounter. Myself and Physiotherapist present.	Physiotherapist visited to ask what time she would see the patient for the purposes of his treatment.	Physiotherapy

SHIFT 0800 - 1600 Hrs.
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initia
14-30 Hrs	By the patient's bed.	Pre-arranged encounter. Myself. Physiotherapist. Physiotherapy aid. My associate Nurse. The Patient.	To lift the patient from his bed to the Tilt table.	Physiothe

SHIFT. 08.00 - 1600
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initia
15-00 Hrs	By the Patient's bed.	Pre-arranged encounter. The Patient. The Physiotherapist. Myself. The Physiotherapy aid.	To lift the patient from the tilt table back to his bed. Included some discussion regarding the treatment between myself, the Physiotherapist and the Patient.	Physio the

SHIFT 1430 - 2030 HRS
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initia
14-00 HRS	Nurses Office.	Pre-arranged meeting. Present Myself. Associate Nurse. Nursing Auxiliary.	My Associate Nurse was passing on a message from the Physiotherapist regarding a new element in her treatment of our Patient.	My Assoc N

SHIFT. 0800 - 1600
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiat
11:30 Hours.	The ward meeting room.	Regular - MDT meeting. Present: 3 Nurses Nursing officer 4 G.P.s. Physio. O.T. Consultant Geriatrician. Social worker.	To evaluate the progress of our patients and to discuss future developments.	By myself.

SHIFT. 1230 - 2030 Hrs.
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
15-00 Hrs	At the nurses station.	Chance encounter. Parent. Myself Physio.	The Physio asked to bring to my attention a new development in the Patient's progress.	Physio.

SHIFT 0800 - 1600 Hrs
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiat
11-00 hours	Ward meeting room.	Chance encounter. Present. Myself. Physio. Nursing Auxiliary.	1, For Physio to arrange a time to give our Patient his treatment this afternoon. 2, To discuss his progress.	Physio.

SHIFT 0800 - 1600 Hrs
(time shift started and finished)

RECORD OF CONTACTS MADE re PATIENT X

WHEN (Time)	WHERE	WHAT TYPE	WHY (purpose of contact)	WHO initiate
11-30 Hours.	By the Patient's bed.	Pre-arranged. Present: Myself. Physio. The Patient.	To prepare the Patient for treatment with the Kromayer, and to discuss the same treatment.	By myself

Appendix E

Examples of collation of data from diary sheets

DATE	PM (PRIMARY NURSE)	AR (SUPT PHYSIO)
24.11.87	11.30am Tuesday case conference	11.00am Tuesday case conference
	2.30pm chance encounter to discuss patient and trial	2pm face to face chance encounter to discuss patient and trial
	2.30pm watched physio doing passive exs that she wanted nurses to carry on with.	(not recorded)
25.11.87	OFF DUTY	11am contact with associate nurse to arrange suitable time for treatment
		12.15 contact with associate nurse re handling patient and transfer onto tilt table.
	15.00 chance encounter to pass on information re tilt table	(not recorded)
26.11.87	(not recorded)	2pm nurses station to check primary nurse aware of patient's progress on previous day and discuss suitable time for treatment.
	2.30pm at patient's bedside with physio to watch tilt table and discover how patient felt about it.	(not recorded)
27.11.87	2.30 at patient's bedside with physio, patient and patient's wife. physio popped in to inform primary nurse of time she wanted to treat patient.	(not recorded)
28.11.87	DAY OFF	(Saturday)
29.11.87	DAY OFF	(Sunday)
30.11.87	DAY OFF	(nothing recorded)
01.12.87	DAY OFF	(nothing recorded)
02.12.87	1.30pm nurses station chance encounter re time physio could do treatment	(not recorded)
03.12.87	(nothing recorded)	(nothing recorded)

DATE	PM (PRIMARY NURSE)	AR (SUPT PHYSIO)
18.12.87	11am ward meeting room to arrange time for treatment and discuss patient's progress.	11.30 ward quiet room to discuss patient's treatment and condition
	(not recorded)	3.30 transfer onto tilt table
	(not recorded)	4.30 transfer back to bed
19.12.87	DAY OFF	(Saturday)
20.12.87	DAY OFF	(Sunday)
21.12.87	PATIENT DISCHARGED	PATIENT DISCHARGED

Immediate comments on collating diary sheets:

1. *many contacts about arranging times of treatment*

2. *no contact when PM not there eg. for week's course*
   one 9 day gap; one 4 day gap

3. *some contacts not recorded particularly by physio –why?*
   not important?
   not considered to be communication?
   not interested in trial?

4. *no discussion recorded prior to discharge*

5. *to what extent do both parties rely on written notes for information – both to pass it on and to receive it?*

Appendix F

Examples of interviews with physiotherapy and nursing staff

Interview with [redacted] - Primary Nurse - Whitworth

Patient you and Anne were filling in diary sheets over - can you tell me a bit about him - nursing aims.

Initially when we got this chap in we were introduced to him by the District Nurse who - he was a chap who normally is not the sort of patient we would have on thisward - he is actually of a younger age group than the patients we generally tend to get in here. But it was agreed that we would have him on the ward for a while in view of the fact that he was living in Matlock with his wife and that he is a paraplegic patient andquite heavy and difficult to look after - on a daily basis - his wife found it a struggle - and perhpas lacked advice and some direction in respect of say aids that could have helped her - breaks - respite care that sort of thing and also from the point of view of the patient himself he was physically at quite a low ebb - he had two quite extensive pressure sores which he developed in the community and had from time to timebecome infected and so physically he was quite run down - andtherefore we had him in to essentially assess him in the first instance - what we could offer in the way of help was in terms of physical care and also for his wife what we could offer her and also physiotherapy in terms of what Anne could offer him as an in-patient - in other words have a totally new look at him andsee if she could offer him anything - physiotherapy type aids and that type of thing. Therefore I think the aims initially were merely to determine what we did - what we found out andwhat we could offer to both him and his wife - because it seemed that his wife had got to the stage of not going to bed just to turn him - she had latched on to the idea that turning was an important aspect of prevention as far as pressure sores developing and she had taken to snatching the odd five minutes during the night in a chair in the living room and it seemed to me there was a real danger of there being two people ill in the household... the patient himself and his wife. So I think those were the aims initially.

Was he incontinent at all? Wasincontinence a problem?

Um - no not really - his physical condition meant he had no voluntary control over his bowels or his bladder - he wore a sheath, he wears a sheath I should say - essentially he dribbles urine continuously and as far as his bowels are concerned he has a manual evacuation every day - so from that point of view he had an incontinence problem but it was a problem that was fairly well controlled.

What about the pressure sores - what sort of things were you looking at from a nursing point of view?

When we first had him in the pressure sores were quite dirty - he had been treated at home for infection and therefore both of thepressure sores were quite sloughy as a result of the debris and the necrotic tissue developed asa result of thatinfection. So the first aim was to get them clean - andit was difficult to know from a nursing point of view at that stage what we were going on to - because at the time we - it was indicated that he had had a lot of treatment for pressure sores and they had not really responded very well - he tended to go out of hospital and develoo infection in the community which set him back again. So at that stage we wanted to first get them clean - get in touch with the liaison sister at Lodge Moor who hadhad a lot to do with the care of his pressure sores and see what she had done and what her feelings about them were and then to take it from there - now having done that we felt that it would be wrong not to try to attempt to treat them - not to try and actually get some healing- some granulation going - because he's not old - he's only a young chap and I think that it seemed after discussion with the liaison sister that there were things that had not been tried so it - there was room for a different type of approach and therefore having got them both clean we decided to try different types of dressings - discussed them with the pharmacist

who attends here quite regularly and is quite on the ball as far as new dressings and concerned - and then see whether we could get something so having desloughed the larger of the sores we tried silastic foam which is a space-occupyingdressing - a yellow sponge - basically it occupies a space which stimulates granulation. Now unfortunately he was discharged from here with silastic foam in sity in one of the pressure sores. We had the district nurse in to see the dressing because quite a few of them are not familiar with the material and it's a fairly complicated type of material to deal with because you have a chemical and a catalyst and you mix them together and you then have only a short time to pour them into the wound before it starts to expand.... and set. So we went through that with the district nurse and we got a few boxes so they could use them but unfortunately after a few weeks he developed an infection - and the foam in a sense seemed to exacerbate the infection in the way that it was able to maintain the dark moist environment for the infection. Therefore this was discontined. My feeling on the matter isthat if we had been able to keep Alf and if Alf was agreeable to staying in hospital for a lenght of time we could perhaps use silastic foam - I feel that because there is either myself of the associate nurse dealing with dressings of this type we had a greater degree of consistency in managing the material in cleaning it and replacing it - I feel that also in hospital itis perhaps easier to maintain an aseptic environment when dealing with these things than itis in thecommunity and I feel that from that point of view we may well havegot it to work. But I think more importantly than that, from a psychological point of view we don't feel that Alf would havetolerated a long period of hospitalisation and therefore the idea of trying that in the future is really a non-starter.

(A short discussion followed on the use of silastic foam - showed a high level of understanding of how this dressing worked.)

What about the physiotherapy intervention for the pressure sores? How do you see that fitting in with what you were doing? or was it something totally separate?

No - what we - the actual physiotherapy intervention in respect of the sores - the Kromayer - a sort of UV thing - Anne or Trish or whoever was on would treat daily the sores - the idea being that she would treat the wound edges to prevent over-granulation because we thought there was a danger of the would margins - the seemed to be healing more quickly - granulating more quickly than the actual fundus or the cavilty - thesame with the other sore and therefore it complemented what we were doing - treating the margins prevented the over-granulation of the mouth of the sores. And we therefore got together and discussed the routine of how we could manage it and what in fact happened was that we arranged to take the dressings down in an afternoon so that Ultra-violet treatment could be used and we could re-dress afterwards so we were co-ordinating so we were dealing with it at about the same time.

Did that work out okay?

Yes - there were no problems - it fitted in very well because there was a lot of nursing involved with Alf and in order to have got everything done we - it meant that we could get certain aspects of the care done in the morning - sorted out in the morning and then go on to do the dressings in the afternoon so that he had a break. It meant that Alf wasn't getting an intensive period of intervention in one part of the day and fidding it irksome - he got a breather in between. And I think as well being a sociable chap he enjoyed the society involved in having different people involved in his treatment - the physios in the afternoon - the nursing staff doing his dressing - different staff to the morning staff who had been on and dealing with the care given

during themorning - he seemed to quite enjoy it to quite look forward to it - he seemed to see it a s a natural puntuation to things - oh Trish will be along in a minute or Anne will be along - he seemed to quite appreciate it.

He wasin a wheelchair was he - most of the day?

No, we nursed him in bed - we tried to work things so we were getting him up about dinner-time because we liked - he liked to sit up during some part of the day - initially when we had him in we wondreed - physically he was so weak - as a result of infection he had just had that we nursed him in bed all the time - but from a point of view of mental well-being we got to the point that we asked him if perhpas he would like to sit up for some part of the day and he actually incorporated that into hisroutine - what we would tend to do was get him ready for about 11 - he could then wheel himself into the washroom - wash and shave himself and xxxx by the time that was carried out it was time for him to go along to the table for hisdinner - by the time the physiotherapist was ready to start treatment on the sores we would be talking about half past one, two o'clock and it would mean he had been up around three hours which was tolerated quite well - he seemed to be able to manage that in the chair for that length of time without any great detriment to the sore or the skin.

Thanks - can we move on a bit more generally to physiotherapy - what are your views of physiotherapy with the elderly - what do you think physiotherapists working with the elderly actually do? What's their main contribution?

I think that having worked here two years - one of the major manifestations of deterioration or illness - even if it doesn't directly affect the

patients mobility like a broken neck of femur or a stroke - they may have a chest infection or something like that... there's no doubt about it that nine times out of ten the persons gone off their feet - and certainly elderly people find it very difficult to get going again and therefore I would say particularly in a community hospital like this physiotherapy input is invaluable - in respect of getting people going - for want of a better expression. When we started here most nurses I think would admit that in general hospital you tend not to work very closely with physiotherapists - people tend to work in isolation - that's been my experience anyway - and therefore when you're working in a community hospital there tends to be an overlap in roles - nurses have often lacked the expertise in regard to getting people mobilised again getting people out of chairs - looking at mobility from a point of view of safety and adding to quality of life - looking at what's practical - this sort of thing - I think nurses tend to look at it in black and white terms - you're either mobile or you're not - and therefore we tend to work very very closely and there's a lot of two-way education where - speaking for myself I've learned a lot in respect of dealing with stroke patients adn how to transfer - correct positioning - the rudiments of getting people tranferring, standing, weight-bearing - this sort of thing - preparation for walking - so I think that's absolutelt vital - because there's no doubt about it that nurses tend to know very little about these things - as I said earlier we tended to work in isolation and not in a true multi-disciplinary setting and you don't really observe what other paople are doing - you know they're doing it but you don't really either have the time or care to take the time to look howit's implemented. I think it's different here .

Is there overlap between what you and the physiotherapists do?

Yes - I would say so - to take mobility as an example - there are time

when the physiotherpist is here - at particular time of the day but she can't be here all the time - it seems to me that she will assess the patient - she will devise a plan based on what she feels is needed in order to improve mobility, or to acheive mobility in the long-term - but the only way to achieve that is actually to rely on people who are there all the time and this is where the overlap because it's necessary for the nurse to carry out that role in order to maintain continuity - so what tends to happen is that the physio's main input is in terms of mobilisation or re-mobilisation so therefore I work very closely with Trish - I ask her what are you doing - what do you want for us to do - and she will say - she will tell us what equipment she wants us to use - she will suggest ways for us to use it - how to stand a person - to ensure they get balanced - to ensure they're square - she will, I like to actually see Trish doing things with the patient so that you get the little things - how to get them to move their foot through when they tend to drag it - often these things are difficult to get across just talking about it - having a verbal report -I think it's important to see what she's doing and then I will interpret that into a careplan that is available to the nurses and we will discuss it and go through it practically and in theory and we will put it into practice during the time Trish isn't here. During the morning, during the evening and at weekends. I think initially when we first opened here there were a lot of difficulties in regard to this question of overlap - because we knew we were starting with a brief of primary nursing - but and yet we were working in a multi-disciplinary team - there was no job description as such - of what role a primary nurse has - the areas in the country where primary nursing had been used have been different settings - Burford there's no multi-disciplinary team approach - the nurses tend to call upon the expertise of theres when they see a need for it - for it to be appropriate - and so the difficulty we had was we had a description of

how primary nursing was developed at Burford but nothing more to work on and so we had a situation where there were a lot of bruised toes because the nurses tended to not intentionally muscle in on other peoples' expertise but it was a sense of not really knowing where you were supposed to pick up and where you were supposed to leave off - and I think it caused a lot of ill-feeling. Situations where as a primary nurse you had to start devising programmes of re-mobilisation of exercises to affected limbs as in the case of a stroke without referring to the physiotherapist - often based on the fact that we'd seen the physiotherapist use that particular technique and taken it on board and tried to apply it to everybody. And that was dangerous. But I think it was something we all had to go through - it was something we had to live with because it was a time of study and exploration we were trying to see what our role was and how it linked in with other people. I think now the situation has improved immensely - we are much more aware of each other - I'd no sooner dream of exercising the limbs of a stroke patient - except perhaps in a rudimentary way an acceptable, a safe way without first referring to a physiotherapist and waiting their assessment, than prescribing medication - that's not my role. and I don't see that initiating treatment into those other areas as my role either. I see my role as complementing those of the physiotherapist and maintaining the continuity of it all but very much referring to them all the way along the line - which we were not doing at first.

Talking a bit about multi-disciplinary teams - which you've already mentioned - what's your understadning of a team -what makes it different to everybody doing their own thing and getting on with it?

Well I think communication - is an important aspect. I think it's very easy to work in isolation of doctors, physiotherapists , occupational

therapists - I've experienced it myself where you're working in isolation from each other- you have the situation where - to take the physiotherapist as an example - she may wish to mobilise a person in a particular way - and will do it twice a day - when she's available to see the patient - in themorning and the afternoon - but the rest of the time the nursing staff will mobilise the patient in the way they have devised themselves - without regard to what the physiotherapist is doing - I've seen this happen many times. I think the difference with a multi-disciplinary team is that there is communication - there is a rapport developed which enables you to take regard of what expertise each person has and to in a sense by discussing problems with members of the team who have particular expertise to offer - and to try and work together to devsie ways and means of either alleviating problem or diminishing that problem - in other words I think it is working together - something I touched on earlier - the idea of being aware that somebody has expertise in a particular area and that you need to pay regard to that in order to maintain consistency in that particular area. I think that's important. I see my role as being a source of liaison within the MDT. Because I spend a lot of time with the patient - actually more that other members of that team, I spend a lot of time in discussing problems of the patient - problems as they see it and problems as I see it - and taking them back to the members of the team and perhaps being in a sense - acting as a patient's advocate. On many occasions I may say well Trish we tried walking Mr so-and-so with a rollator frame but he doesn't seem to be happy with it - it may well because as a nurse I'm with the patient longer over a greater period that there are certain aspects that I can pick up that other prople whose dealings areperhpas more transient don't initially pick up. And from that point of view - if you were to come into a MDT meeting you would see that the nurse is in a sense - I don't like to say it because I like to think that the patient is at the hub of things - but I think that the nurse tends to be a

central character as far as handing on information - just touching back to the team - I think one of the ways we got over the problem of overlapping of roles was in making the patient the centre of care. In other words not seeing the patient as being a collection of separate problems which were susceptible to nursing intervention more so than physiotherapy - more seeing the patient as the centre of things and the problems as perhaps being problems that anybody could in fact have - often when you think about these things it is difficult to put them into words because they're so implicit - I think what it was we did was by makingcarepatient centred - by being aware that a patient had open access to any member of the team that we had to deal with the problems together not in isolation from each other - we were aware that maybe a straight forward nursing problem such as encouraging expectoration in someone who had a chest infection - there were obviously aspects of that particular problem that could be dealt with by the physiotherapist - for example the physiotherapist could come along and ~~xxxxxxxxx~~ assessx a patient's chest and perhaps suggest a regime of chest physio - the nurse could then carry out some of the treatment and incorporate it into the rest of the care. It's very difficult to try and put it inot words - it seems to become instinctive which perhaps is a good thing - initially we had to think about it - perhaps two years ago I could have explained it better.

So most of these things arethrashed out at the team meeting? (Yes) Are you aware that anybody takes a leadership role at the team meetings? Doesthe team have a leader?

I think sometimes it does - Ideally I feel it shouldn't have to have a leader in the sense of someone who dominates the proceedings - I think sometimesit does- I'll explain what I mean by that in a moment.

What I just wanted to say was I feel that carrying on from what I said previously, often the nurse because they have a lot more personal dealings with the patient over a greater period of time, they tend to in a sense initiate the team discussion in assessing a particular patient - in other words if a patient is brought up it is very often that other members of the team will look to the particular primary nurse to initiate a discussion as to howthat patient is. I don't think that'sa bad thing - it's a bad thing when a nurse starts to discuss every single aspect of what happened to that patient in the week. What I like to do is I will tend to make a specific comment on what I've observed over the week - but if it's something which impinges for example on an aspect of patient function where another person's expertise may well be necessary to call upon then I will do that - I will tend to say - well we've been walking this patient over the weekend - I must say I found him inconsistent - how do you feel about that Trish, and is there any advice you could give us in respect of that and this is the way I tend to do it. I do feel that the nurse - perhaps because of this patient advocate role tends to have a lot of information that is often useful in initiating the attention of the team on that patient - I like to try to put the patient in context because often I find that because Dr. [redacted] sees so many patients and is only here twice a week you can often discuss a patient who has maybe been on the ward two or three weeks and it's only halfway through the proceedings that Dr. Asher is aware who it is we're talking about. Because he sees so many people. So I tend to try to put the patient in context so Dr. Asher knows who we've talking about and then it seems to create a natural progression so ~~xxxxxxxxxx~~ the rest of the team can then comein with what ever it is they feel they want to say. For example, I will often say if you recall this is a person who is 75 lives at home with her husband halfway up East Bank and then immediately you can see the people thinking oh yes East Bank - that's

that area that's way up - up narrow winding streets, and it puts the person in context - people are already thinking ah yes that's a bit inaccessible to get to - I find that seems to be a mush better approach- I think you're aware that people are actually listening and taking an interest, whereas the danger - the thing that happened before was that as a nurse you tend to say - something like - oh yes this is a person who came in with a stroke and they were pyrexial when they came in - it's not telling you anything about the persona a t all and that's the type of thing that usually happens. And you tend to get a situation where the nurse is talking about things that she sees asonly concerning the nurse and the physio comes in and talks about physio problems the OT will talk about things that relate to her expertise - the nurse will then come back and talk about nursing things - in other words you've got these slightly fragmented things that have been talked about - and you're not xxixx really seeing the person as a whole - that's how I feel anyway.

What about the notes - you've got a different system of record-keeping here - could you tell me a bit about the function of the notes.

Yes - well essentially the notes- are you referring to what we call the nursing notes? (Probably). It's a bit of a misnomer really because we try to make them everybody's notes - well I better qualify that I suppose - everybody who has a legitimate cause to deal with that patient, ought to have free access to those notes. They contain the patient's drug prescription - they contain the documents that we have to fill in on admission and they contain basic information - address, next of kin religion and that kind of thing - they also contain information regarding the patients domestic set-up - whether they're married but also whether they have domestic help, a social worker, whether they have a district nurse, whether they have meals on wheels, home help that type of thing

we have a Norton scale included as well which we fill in when the patient's admitted - and we also fill that in after a week or halfway through the admission as a comparative thing - and then the rest of it is made up of the initial nursing assessment what they felt anxious about, what they saw as their main problems, why they' thought they'd comeinto hospital - this type of thing, a list of investigations blood test, X-rays that type of thing.(short discussion of why it's important to know eg if Xray film gets lost). Then we have the sheets which the primary or associate nurse will start to draw up a care plan on with the patient. We have a separate sheet which the physio fills in so it's there to be seen in the notes by anybody who reads the notes and a separate OT sheet. Now I feel that - I've often felt that it would be a better arrangemtn perhaps if we could have common notes - I know we tend to feel that the nurses tend to do the nursing careplan but often what you want to refer to on the physio sheet - an aspect of treatment that you're not sure about, an aspect of exercise or to do with mobilising - this sort of thing - what type of frame ought to be used - in the situation where you've come on over the weekend and you've not been able to speak to the physiotherapist and you're relying on what's written down to tell you where you're going in the line of exercise or treatment - and I mustsay there are times when I've found it difficult to interpret what the physio has written down - perhaps because of the way - the abbreviations the shorthand - common to all physiotherapists but not to a nurse - they're written for other physios not for - and when you've got different coloured sheets, blue for physios, green for OTs - there is a tendency to feel that that sheet is for the physios to write on and perhaps that explains why - perhaps we all of us need to be a bit more sensitive to the way we deal with documentation - as to who's going to read it. So that we can all understand it - so this is a policy type of thing and that the things that are written shouldn't have a negative content - to take an example - purely hypothetical - instead

of writing something like - this person may not ever walk independently again - to try and describe it in a more positive light - we may be able to get this patient to walk with a zimmer frame - unless of course you've explained this to the patient what the outcome is. I think that the notes ought to be written in such a way that the patient could read them without feeling anxious about anything that iswritten in ther. Alf actually had access to his own notes (how common is this) not common - he's the only one. (why) Well, I think we wanted to try this out because there were various moves to questionaing the idea of whether patients should have access to their own notes

Interview with [redacted] cont.

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well I think we wanted to try it with Alf because there were various meetings and moves which seemed to be going around the district that was questioning the idea of whether patients should have access to medical notes

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patients reading medical notes is something I think which perhpas doctors, medical personnel have resisted quite fiercely in the past. Often if you read medical notes the style and manner in which these are written - you can perhaps understand why - but it seemed to me that it was an inovation really, that - I think that nurses and perhaps paramedical people have often been the most innovative within health care settings and I felt that

it was worth having a go and seeing how it worked out. Alf is an alert person, an intelligent man - was able to contribute a lot to his own care - when he first came in he was the person who told us how he wanted things to be done, and he was the person who identified what the problems were so it seems only natural in view of that that he should see how those thoughts, feelings, impressions were being interpreted and see how - so he could actually monitor whether the staff he was seeing every day were carrying out those aspects of the way he had verbalised them - and whether the care plan was true to them - so I think from that point of view he seemed to be a reasonable candidate.

(Was this successful?)

It's difficult to say - he seemed to feel that the plans were true to what it was he wanted - he appreciated

aspects of the plan that he didn't initially understand - things that perhaps we were doing because - based on nursing expertise - looking at a problem and saying yes Alf wants us to do that but we perhaps need to do it in a slightly different way, a modified way to prevent complications. But, then we would always explain that to Alf anyway, he always knows what the score is and what it is we are doing, and what it is we want him to achieve - and therefore it wasn't so much of a surprise to him to see what variations there were in the plan from what he initially wanted to happen because it had been explained and he seemed to appreciate that. Unfortunately it's something that's not being carried on because of the difficulties recently we have had on the unit - I think it's true to say that primary nursing in the way that we were carrying it out at first hasn't been carried out

for a number of weeks. 033. We have staff leave- one leave for maternity leave and one leave to do further training - we were told that these people would be replaced and they were not so actually we are in the situation where we were expected to maintain the same service but with fewer nursing staff - also there has been a lot of sickness - we are actually in the situation at the moment were the ward across the way has closed down so we have got some Winster ward patients and some Winster ward staff. We've had the situation where because of sickness the primary nurses have had to 'caretake' somebody else's patients which is difficult if you are not familiar with them. And I have to say to be perfectly candid that when it's busy and you've got few staff on it is very very difficult to take the time out to sit and read somebody else's details to see what you need to be doing - and there have been times

where we have had to really shake ourselves and have a new look at what we're doing because we're slipping back into the situation where you are transferring people in a way that has not necessarily been prescribed for that person. In other words - just basic nursing care - the individualised care - you can't provide. So it's been a problem. I think this has been reflected in terms of staff morale, I think staff morale has suffered and to be quite frank with you I can't see things settling down in the foreseeable future - I'm leaving, there's another primary nurse who may well be looking for another position in another hospital - not because she's necessarily disillusioned, but because she was only taken into the primary nurse role on a temporary basis anyway - and I think until the jobs are advertised, new primary nurses are employed and the staffing situation settles down,

thsoe new staff themselves start to settle down - it could take six months, probably a year for them to get to grips with the role of the primary nurse - then I think things will be unsettled.

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(What does the term care mean to you - particularly care of the elderly?)

Care of the elderly - well - what it means to me is trying to (pause) I'm just trying to think how I would word it because it means such a lot actually - I can probably tell you more easily what it doesn't mean - it doesn't mean imposing care on people, it doesn't mean looking at somebody and determining what would be good for them - and imposing that on them - I think what it means is supporting people in developing an optimum level of independence - in a nutshell that's what it means to me

- practically what it means to me is working in partnership with ~~them~~ and trying to find out what they have had before in the way of physical well-being and looking to see how far you can work towards reaching that again - or with the other members of the team getting together with the patient and perhaps saying to them well we can't promise that you are going to be as you were before but we can perhaps help you to be eighty per cent towards what you were before - in other words it may be that instead of being able to walk around the house unaided, climb on chairs, hang curtains - this sort of thing - you may well have to use sticks, or a zimmer frame or you may well have to take it easier - you may have to get somebody else to stand on the chair and put the curtains up - this type of thing - there's no reason why you shoudn't be able to ~~have~~ some quality of life within that situation. So I think

it's trying to maintain independence and I think that's important with elderly people because I think it's the thing that keeps them going - that's a personal opinion. Often it's risky because what a person wants to do and what a carer would like them to do are often poles apart. I can think of a number of situations - patients that we have had on the ward, that I've been involved with as the primary nurse, who have wanted to go home and carry on living at home and you look at them and think well how the devil are they going to manage? Even getting them as well as we can - the best that we can get - how are they going to manage - but I feel that if a person wants to go home they most have the right to go home even if it's a risk - I think we've got to respect that and help them towards it - perhaps it means getting together with OT, physio, doing home visits, looking at what can be put in in the way of

domiciliary help, talking to the patient about what they are going to do - saying well your aim is to go home but having been home with you we feel that perhaps you need a few alterations with regard to furniture - you might need a higher chair - you might need to move some of your stuff out so you have got more room or whatever, it may mean that you need someone to come in and help you into bed at night - you might need the district nurse in to help with the catheter - there's all manner of things - discussing that with the patient because at the end of the day it's very important to bear in mind what their aim is and no matter how unrealistic it seems initially to try and look at ways of trying to help them get there. Because I feel that even if somebody goes home and has an accident - falls down the stairs or whatever, at least at the end of the day they've been doing what they want to do. And if

that means they were happy right up to the moment they died then that's well worth it. So that's what I think caring is about - supporting people towards optimum independence.

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(Do you think that the physios you know have a similar understanding of care?)

(Pause)

As you know we have two physios working on the ward - I think that perhaps one of the physios very much has similar attitudes to what I have described to you - about care - I feel that perhaps the other physiotherapist who works with us doesn't and often it's very difficult to work alongside her. (Pause) There are instances where perhaps in the multi-disciplinary meeting while describing what a patient wants and often this particular

physiotherapist - it's difficult to interprete how she feels because I don't know what goes through her mind or what her attitudes are towards care but I think that she does tend to look at people and see perhaps a deficit that she feels she can improve and impose a regime upon that person without necessarily asking them what they want to achieve - what they feel the problems are - (Pause) without really consulting them as to what that regime of exercises or whatever may involve and it's difficult as a nurse because when you are looking at what has been prescribed and try to interpret that I have often found a great deal of resistance to carrying out those exercises because they've not really wanted to do it - it's not really what they wanted to do - it's not aiming towards what they want to achieve - and that's often been difficult.

(So what I'm really driving at is if professionals are working together in a team and they have different philosophies of care - how does that manifest itself? Does that cause stress - what actually happens if people are working to different understandings of care?)

I think it does cause stress - it causes a lot of antagonism it will manifest itself in (pause) in this particular instance - in respect of the person I have in mind - I find it very difficult to go and say look we're having problems here because the patient doesn't want to do what you have said in this regime, because often she becomes antagonised by that statement and will not really offer anything else - there's a degree of inflexibility in this - she will not sit down and say okay let's have a look and see if there's something else we can negotiate -

see if there's something else we can do - I'll sit down and explain what I was trying to acheive and see if the patient will accept it - she tends to see it almost as a criticism - a snub both from the nursing staff and the patient and often will respond by withdrawing care so it's very difficult and I think we have had - well I won't say shouting matches because it's not a two-way thing but arguments that often occur because of such a situation, and it's not infrequent - and that's how it manifests. The problem is that this particular individual is very, very expert in dealing with stroke patients and (pause) I think the stress that I often feel is that you are aware that there's an expertise there that you want very much to have access to but often because of the personality you can't get it - I find that a problem.

(Do you think it's a problem for the patient - in terms of the care they eventually receive?)

Yes - yes - as I indicated earlier they may often end up getting nothing - or if they do get something then there's an element of hostility involved in the giving of it unfortunately. (Pause)

(Questions about self - training etc.)

left school - didn't know what to do - drifted through school - then drifted into a job I didn't really like - I was training to be an accountant - I got onto a commercial apprenticeship -trainee accountant - day release to college - very solitary work - preparing figures - on own a lot - not really interested - no aspirations to be an accountant - I've never felt myself to be an academic so I felt if I wasn't really interested then I wouldn't be motivated to work for the exams - I was unemployed for a

week - couldn't stand it - labourer in steel works - physical work - I didn't enjoy it at the time - in retrospect I'm glad I did it - met good people - did me good - a lot out of it. University - psychology couse - doing A-level sociology but didn't get good enough grade - so I applied to Middlewood hospital to do RMN - seemed appropriate - to do with psychology - surprised I was ever offered a place - I remember saying at the interview - I don't really want to be a nurse - just a stopgap - once I got into it I began to get a lot of satisfaction out of working with people - structure back in my life and I started to feel it was what I wanted to do - stayed the full three years - forgot about psychology. 226 3 years at Middlewood. Went on to work on acute psychiatric ward. Got interested in the elderly - because the elderly get a bad deal - the mentally ill get a bad deal anyway - but if

you're old and mentally ill - the psycho-geriatric wards tended to be overcrowded - overpoplated - the nursing expertise was minimal - often there seemed to be a policy that nurses who were coming towards retirement were put onto geriatric wards because it was felt they were less stressful - it was a nice way to finish your working life - and therefore there seemed to be a lack of motivation among the staff and I don't think I ever saw a physiotherapist at Middlewood, I never saw an OT. Often you would have a 30 bedded ward with one trained nurse - the rest were nursing auxiliaries - not given any direction at all - just tasks - getting people up, toiletting them, sitting them in a chair, feeding them, toiletting them, sitting them in a chair, that type of thing - it just went on ad infinitum. And yet it seemed to me that there must be a better way of nursing elderly

people -I didn't know what it was at the time.

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I was working on a acute admission ward at the time and I felt that in order to nurse people in a different way you needed to take regard of physical aspects because I always feel that psychiatric nurses tend to have a total disregard of physical problems - and that you tend to try and put - because of your lack of physical expertise - you tend to put any physical problem down to psychosomatic problems and I felt it was necessary to take a wholistic view - although I wouldn't have know what the word wholistic meant at the time - looking at people as a whole individual - and I applied to Chesterfield and got onto a short course and working for 18 months at Calow and hated it - hated every minute of it - I think I hated it because it was just like it had been at Middlewood and I had

expected it to be different somehow - it was just task allocation - also there were a lot of odd things that struck me - the school of nursing was very good at Calow, I have to say - they were very motivated - they visited and supported you in the best way I suppose they felt they could but from an in-service point of view the actual experience on the ward was very poor -as a student you tended to be treated as a extra pair of hands - you were skivvy - and I can remember the first day I was there I was given the job of cleaning snow - imitation snow off the windows after Christmas - and I can remember thinking - oh God I've got 18 months to do a nurse training course and they've got me doing this and they sent me off early after that - and I was really upset they sent me off early because I felt I need to know things - I need to have some objectives not just drift through like this. I suppose

things got a bit better, but I think nursing is very much a do-it-yourself course - mental nurses or general nurses - by that I mean that lot of the work you need to know to get through an exam you find it out yourself - you get books - and find it out - often if you ask someody, unless you ask somebody who's very expert and enthusiastic in a particular area then they either are very unsure about teaching and therefore don't explain things very well or they don't know and very often they try to cover up the fact they don't know by giving out erroneous information that doesn't really help you. And I think the other odd thing about Calow as a hospital is that because they originally transplanted it lock stock and barrel from the old Royal, you tended to find you had situations on wards where you had a ward sister who had been a ward sister for many years and she had a deputy or senior staff nurse who

she was training up to inherit her post - and in certain instances there was almost a situation where people were promoted by a process of dead men's shoes - they'd literally inherited the job from the ward sister. I hope and pray that things are changing - I think they'll have to because it's such a big hospital that it needed many more staff to actually go in because there were many more wards than at the old Royal. And I think whenever you get new people coming in you get change. But I didn't much care for things. And when I had actually finished my 18 month course there I had a letter sent round describing W[redacted] Hospital, B[redacted] Ward, Primary Nursing - it talked about Primary Nursing - it talked abou the type of people they were looking for to be Primary Nursing and it really appealed to me - in a sense it actually started to clarify the sort of thing I felt ought to happen on

wards for the elderly. I didn't really think about primary nursing in terms of acute surgical wards or orthopaedics, but certainly in terms of the elderly it seemed like a godsend. And I was lucky enough to be appointed here. But I feel that the Authority have treated the Unit pretty badly in terms of funding - and support, often they've said one thing to us and something entirely different has happened. For example, you'll be getting such and such in the way of staff or people will be replaced and they haven't. And the place has been under-funded - they were always very quick to bask in the reflected glory of having such a unit in this area - the number of people we have trooping through here over the two years it's been open has been incredible. You almost get a feeling that it's a bit like a shop window - which is an unfortunate thing. And I've found that stressful -

I do feel a loyalty to the unit and to the senior staff who work here because I don't think it's their fault it's happened - I am very much aware that they have fought tooth and nail to try and get as much in the way of resources and staff as they could for the unit but I feel that they've done all they can and they can't do any more. I think that they senior staff have been honest enough to say to us that they've done all they can and they are no longer able to influence the powers that be in respect of financing the unit the way it ought to be and the way we feel it ought to be and therefore I don't feel any sort of animosity towards them - but I do feel that it's been a bit irksome to try and face visitors coming on the ward to talk to them about primary nursing in a sort of idealised way that I know in my heart of hearts we're not practising. And that's been a bit stressful.

(And you're moving on now to Bolsover?)

Yes, not because of the problems, I'm moving on because I feel that I could very easily stay here and not look for anything else - I would find it very difficult to motivate myself and look for another job. I kept saying to myself yes I would look for something else - looking through the papers and carrying on here essentially because I like it. I like it here because (pause) I've seen the system working well early on, even though it's not working well at the moment - and I feel that in the future it could work again if things settle down. Perhaps if we get a continuity of primary nurses - at the moment as I said earlier we've got people who are doing it on a temporary basis and one of the primary nurses is fairly new to the position and needs a lot of support. But I do feel if

things do settle down, even though the place will not be funded in the way it ought to be - perhaps we could aim towards primary nursing. I think it's a good thing to aim towards something like that because even if you don't achieve it at least you, by getting part way along the path towards it, are thinking about the service you are providing. Whereas to dismiss out of hand that you are ever going to be able to primary nurse and to dismiss it means that you are accepting second best - it doesn't make you question what you're doing, looking at what you're doing so I think it's always a good thing to aim towards - I don't think they'll achieve it to be honest - I don't think they'll get the recognition that would be necessary to do so - I think the attitude is there. Primary nursing is merely a vehicle for a particular attitude in care and I think the attitude we have here is patient-centre care

so I think the attitude will always be there but whether primary nursing will be the vehicle - I think in a pure sense it won't - I think we just aim towards it.

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(In discussing potential areas of conflict between nurses and physios, one of the issues that has come up has been uniforms - the saga of the uniforms as it's been called - now you are in your own clothes - why?)

(Pause)

I think that (pause) first of all I should say that we were given the choice on here of whether to go into uniform or not. An both myself and Irene, and Martin who was a primary nurse on here when we first opened, chose not to go into uniform. I think the reason I chose not to wear a uniform is because I've worked on units before where we've not worn uniform and I've always felt that

contrary to belief - people often say that patients find security in somebody wearing a uniform - I feel that it's true to a certain extent in that the person will always recognise a nurse or a physiotherapist by the uniform but I think it's not the uniform ultimately that gives the person security, it might in the initial instance but I think it's the person's approach and attitude that will instil confidence in a patient whether it's somebody you can have confidence in whether it's somebody who is going to explain to you what's happening and what to expect - that type of thing - that's what ultimately imparts confidence and security. But I think the effect it has on the nurse of not wearing uniform - you have to be prepared to perhaps give a bit more of yourself, particularly in the initial stages - I have to say who I am to people whereas perhaps when I wore a uniform people have just come up to

me and told me who I am. Oh you're Staff Nurse, can you tell me so and so. I now go up to people and say My name's Patrick, I'm one of the primary nurses on the ward and I'm looking after your mother, or I'm helping look after your father - that type of thing so I say a bit more about myself. And I don't think that's such a bad thing - because I think what it means is putting things on a bit more of a human footing - I think people feel they can refer to you by name then and people do. People will ring up the ward and say Is Patrick on and if not is Madeleine on or whoever, I've never actually come across anybody who has said to me that they would prefer me to wear a uniform - the only time I ever wore a uniform was the day Princess Alice opened the place and it was suggested that it might be the done thing to wear a uniform - it was either that or wear a shirt and tie and since I had to work I couldn't

imagine working with a shirt and tie so I wore a uniform but I can't think of anyone who said to me on that day Oh I would prefer you to wear a uniform, or anybody who had never seen me in uniform who said Oh we don't know who you are - in other words, once people have got to know me, once I have said who I actually am, if they want to talk to me and are approaching me on the corridor or something like that then they won't look for someone in uniform in preference to me - I've not found it a problem in that respect. (Pause) I think that perhaps in certain circumstances a uniform may well act as a barrier, certainly as I indicated earlier you have to give a bit less of yourself when you're wearing uniform - the uniform is an obvious label that tells the world what you are and what you do and it's very easy then to let people come to you and they will see the uniform and say Oh, Staff Nurse,

or Charge Nurse, Sister or whatever. I think you do have to give a bit more to people when you don't wear a uniform. Because initially they don't know who you are and you have to introduce yourself to them - but perhaps even in certain cases people don't take you quite seriously or there are people who don't (pause) .... if you're in uniform you're a proper nurse - that sounds like a contradiction because I did say earlier I didn't find that to be a problem - maybe the reason I've not found it to be a problem is because I've always sat down and talked to people and when people find I do know what I'm talking about and that I do show an interest and that perhaps they then develop a confidence and think Oh yes well he must be a proper nurse because he's saying this that and the other and I feel confidence - perhaps it's not for me to say that but that's a feeling I have. Maybe that's why

at the Northern General because I used to find that the student nurse, the female student nurses would wear very demure looking caps, and the Staff Nurse would wear slightly more elaborate, and that by the time you got up to the Matron, because they call them Matrons there, you'd have these really amazing looking things with doilies on top of them and I think that people do - there is an element of people sort of enjoying the status related feelings - also the idea of having all your badges on - I've never worn any of the badges I have - I was pleased to have them but I never particularly wanted to wear them because if anything I think they tend to be a bit inhibitory because

END OF TAPE

side 3

000

I think that perhaps there are still a great many nurses who enjoy the feeling of wearing badges and that perhaps it is a status related feeling. I think the thing with me that in psychiatry the uniform you were given to wear as a male nurse was a very poor affair really - in essence it (pause) it tended to do nothing for the image of nursing at all - it really smacked of the old idea of asylum orderly really because it consisted of a short white jacket - the sort of thing you see on movies - One Flew Over the Cuckoo's Nest - that type of thing. So I suppose I must feel somewhere in the back of my mind that if that's all they can offer me in the way of a uniform then I'd rather not. But I think more importantly I feel as I say that it perhaps makes you come forward to people more. You asked me how I felt others - paramedicals would feel -I honestly don't know - I can't answer that - you see the

other thing about uniforms - in a sense the physiotherapist and occupational therapist uniform is a more practical uniform to be worn than ever the nursing uniform is because if you look at the female nurses they often complain about not being able to get their knees up on the bed and this sort of thing, to lift because they're restricted by the skirt, and the hat clearly doesn't serve any purpose now except for denoting whether you are a first or third year student, a sister or a matron - and perhaps those aren't important issues. So I think that I can't really answer how the OT and physio might think about that. Certainly I would say that their uniform is a damn sight more comfortable looking to work in than perhaps the female nurses' - from a practical point of view. I can appreciate how people can feel threatened by virtue of what I was saying earlier - status - the feeling

that it gives you, but I can't - I can appreciate it because I have seen it demonstrated, but I can't understand it because it's a feeling that's alien to me as a person. 027

(I just want to finish off by asking you about physiotherapy - what physio can offer that nursing cannot...)

(Incontinence)

(Pause) I think that with regard to promoting continence, or dealing with incontinence - (pause) I've not always known what physiotherapy has to offer but I can remember first saying to a physiotherapist have you got something to offer and she talked at great length about helping mobility, to help get the patient mobile, and things like

pelvic floor exercises with respect to stress incontinence. At the time I'd never really thought about it - I'd thought about mobility, I'd thought about incontinence - but I'd not really thought about specific exercises - I can see the importance now, I can see the importance of somebody being able to for example, being able to transfer effectively, because there are a lot of cases where somebody is incontinent - if it's an elderly person who is not very mobile, simply because they can't get to the loo in time - and therefore at a very simple level the physio input can help with somebody becoming mobile, the nurses can take on board the advice of the physiotherapist and get the continuity of a programme that would aim to get someone mobile - then clearly they are going to be able to get to the toilet - either under their own steam or at least transfer. And certainly in

educating relatives I know the physiotherapist does a great deal of work with the husband of one of my patients who is chairbound and he couldn't get his wife onto the toilet, and he'd just come to accept the idea that she was going to be wet during the day - now she's not because he can take her to the loo and he's learnt how to transfer - she's taught him how to transfer. So the important thing is not just educating nursing staff in pelvic floor exercises where appropriate, in an on-going programme of mobility - not necessarily where the aim is to get someone to the toilet, but just to get them mobile - in a sense getting them to the toilet would be a bonus in that respect, and educating the relatives.

065

(Pressure sores)

I think that in the instance we were talking about at the

outset - complementing the treatment of pressure sores. I mean there are a lot of specialist treatments that physiotherapists use which aid healing, like ultra-violet, I can't remember the names of half these things - isn't there some form of magnetic ..?

(Megapulse?)

Megapulse, which aids healing and I think again an important issue is helping with transfers - often a physiotherapist has been able to demonstrate a technique to both the patient and nurses which reduces perhaps, friction - this is just an example, lifting someone out of bed - moving them to the side of the bed, then bringing their legs out, then the body, as oppose to lifting somebody bodily across which can often cause friction damage to underlying tissues. And I think that the input there, improving mobility - suggestions of technique or direct

treatment - aiding in transfer will help with the actual pressure sore, it means then that the nurse can along with the patient help to relieve the pressure which may cause them in the first place.

083

(Leg ulcers)

(Pause) To be perfectly honest with you the patients I have had with leg ulcers - have not really had specific physiotherapy intervention aimed at helping the healing of the ulcer. The only thing I can say is I often have asked for their advice with regard to the type of tubigrip - although I have to say that in one particular instance I tend to feel that purely based on my own experience, there is a particular type of tubigrip which is better than one that I know will be suggested by the physiotherapist working on the unit, but then I think everyone has a

feeling for a particular thing if it has been useful in the past, if you can see it has an application with a particular patient - I think if you have a lady who is particularly oedematous and who has a leg ulcer it is very difficult to get shaped tubigrip on and I will often prefer to use the ordinary uniform tubigrip using the applicator, because often you cannot get the shaped tubigrip over the area - the patient goes through a lot of discomfort while you are trying to get the shaped bit over the foot. So I think with leg ulcer perhaps advice with tubigrip, and the type of passive exercises or active exercises I instruct a patient with regard to improving venous return was taught to me initially by a physiotherapist so that's input as well.

(Thank you very much ....)

INTERVIEW - [redacted] PHYSIOTHERAPIST WHITWORTH - 8.3.88

(This is going to be a very informal interview. We haven't got a list of 60 questions to get through. I have got some topics on the cards which I want your views on - I want to get a bit of a discussion going. First of all, thank you very much for doing the diary sheets - it was of great use, I found it very helpful, and I do appreciate that it took time to do them - how did you feel about doing them?)

Um - I was quite happy to do them. Um - it was sometimes quite difficult to know what was perhaps relevant - because I was communicating with different people. In actual fact it worked out that the communication wasn't very ofte with P[redacted] himself but that's just the way that team wrks and so sometimes I wasn't sure if the information I was giving was appropriate.

(Do you feel that it gave me a good overview of the communication about the patient or do you feel that in fact that a lot more communication went on that you couldn't record? Do you think it was fairly accurate?)

Oh I think it could have been more detailed. Er but again as I say I was trying to put down what was relevant. Um - yes there was more discussion that didn't go down because sometimes it was not with the people ~~we were~~ that I was officially supposed to be communicating with. A lot of things get passed on through third parties and so on - with the primary care team.

(Could you tell me a bit about the patient?)

Well he's had a complicated history really. He's a gentleman who started off ~~we~~ they thought he was a Guillaume Barre syndrome and he got gradually worse - he was ~~having~~ known to us in physio before my time, ~~here~~ many years ago - he gradually got worse and ended up with a T11 paraplegia and they then decided it was an angioma that had caused it. So - I didn't know him in the early

I only know him as having

stages at all - been a paraplegic now for nine years and primarily I was asked by Dr A[redacted] to treat his pressure sores and he specifically asked if I would use ultra-violet, which we did. Um, we don't have one here so we had to get one from Calow, with the applicators and so on. And also I thought it was important to do passive movements, and Alf told me he hadn't stood up for nine years so I got him on the tilt table as I felt that would give him a boost psychologically and it did - he was quite emotional the first time he did it and I think that helped also with bladder drainage and that is something I feel quite strongly about having worked with multiple sclerosis patients. So that was the sort of treatment - we talked quite a lot as well - um - Alf's a very intelligent chap and he just enjoyed having someone to chat to as well so there was a certain amount of, you know, informal treatment as well.

(What were your main aims? What were you actually trying to do with him?)

I was trying, in combination with the nursing staff to improve these pressure sores which were very deep and needed quite a long applicator to get to them. So we were working very much as a team on that. They were doing the dressings & the cleaning and I was just doing the ultra-violet and trying to fit in with their routine so I wasn't ripping off dressings when they had only just put them on and that sort of thing. So that's why there did need to be a lot of communication - so that we synchronised our treatment - that was very important. Er and also to save unnecessary discomfort for Alf. So there was as little interference with the actual pressure sores as possible. Um, sorry I've forgotten what the question was...

(Main aims - what were your main aims.)

Main aims - um - I felt that the main aims were to give Alf a feeling of well-being um - I didn't really feel it was likely we were going to heal the pressure sores so although I was treating them I wasn't expecting to

get fantastic results, but I felt if it could make Alf more comfortable then it was worth doing it. Um, but really there weren't very many functional aims, it was to ~~make~~ maintain the status quo and I felt that we could do quite a lot to lift Alf psychologically - so those were my main aims.

(Where were the pressure sores?)

Sacrum. There was one over the - you've got me because this was a while ago -

(Ijust wanted to know the general areas.)

There wasone over the trochanter - he had had an old wound which had broken down. It was basically trochanter and the other one was a little bit further round towards the sacrum. One on each hip which made it quite difficult ~~with~~ treatment wise because of turning him. Having to do one, getting it covered up and ~~then~~ having to do the other one.

(So how did you think that physiotherapy - what specific physiotherapy intervetion did you use? Ultra-violet....)

I used ultra-violet. I did passive movements. And active ~~as well~~ where possible on the upper limbs. And I used the tilt table as often as possible. Alf didn't always want to go on the tilt table - it was you know if he felt he wanted to. Also I should say that that fitted in with occupational therapy as well because once we got him up on that he did do some printing so it ~~worked~~ linked in with the OTs as well quite nicely and that gave him another interest of course which they developed - that side of it. Things that he hadn't done before at all.

(Right, so moving away from this specific patient now - could we just talk a bit about physiotherapy ~~generally~~ with the elderly in hospital

What do physios working with the elderly actually do?

Pause

Now this is from your experience - what you think.

Is this from personal experience of the units I've worked on? or what I hear from other people?

Just generally.

Well I think there are two types of physio that goes on. I've seen the ~~type~~ kind of physio ~~th~~ where you have groups of elderly playing games and activities which-I think it has some merits-but I pefer to treat elderly patients as I treat all my other patients - ~~like~~ as individuals. I'm not a great one for group activities with the elderly. I think the occupational therapy helpers do some quite nice activities with them but I don't see that as the roleof the physiotherapist - um - I like to treat them as individual people. Um and my treatment of the elderly really is very similar to my work with other patients - um assessment, obviously the actual treatment is geared very much towards ~~actual~~ function - um because it doesn't necessarily matter whether you can get your arm up to 180° - but it does matter if you can clean your teeth and wipe your bottom so I tend to make it more functionally oriented but otherwise very similar to ~~other~~ ams physio treatment.

Take the unit then, Birchover ward - what difference does it make having a physiotherapist on there?

Well, with the primary care nursing - we've tried to make it a team approach - now initially we, the occupational therapist and myself felt a bit intimidated by ~~the~~ primary care nursing because we had understood that the nurses were going to do everything - and we would be superfluous - which upset us some-what but we were assured that they wanted to marry

primary care nursing with the multi-disciplinary team approach and once we'd sort of got over that hurdle which took a while with ~~xxx~~ quite a few misunderstandings -

PHONE RINGS - Anne Answers.

(Where was I - talking about the role of the physio...

(That's right)

Right, once we'd sort of sorted that out and um - that took quite a lot of time actually getting the team going, um, and we all understood ~~then~~ what our roles were - although obviously in a team like that there's an awful lot of overlap of roles when you can't be too rigid. Um but there were certain things, like the nu sed wanted to do - put Megapulse on and things like that and we did obviously have to draw the line on some things - although we help to toilet patients and things like that - we do try and work very much as a team - um so the role of the physio I think is very much as a team member - but I think we can offer expertise to the rest of the group um - (pause) - I think that's about how I'd see it - ~~to~~ as part of a team.

(When you mentioned that everybody knew their own roles - what's the ~~xx~~ role of thephysio? - as you see it. What's your understanding of their role?

On that particular ward? to advise the nursing staff on handling ~~xxx~~ thepatients - I think It's a very important role with the elderly. Um, to actually treat where it is necessary - to do specific treatments just like you would with any patient referred to you. Um, (pause) I don't know ~~(pause)~~ because I don't see my role as being especially different to my role as a physio full stop. I don't see why we should treat the elderly as some

Is there any overlap between what you and the nurse do?

Um - yes I would say there's quite a lot of overlap because we don't have any weekend physiotherapy and quite often we have a patient doing certain activities for instance a stroke patient, where they need to be positioned - we'll have charts up so thenurses can carry on with that over the weekend particularly - when we're not there - they will quite often do passive stretches for us when we're not there and even during theweek when we are there if you want - because we haven't got the time in this hopsital to treat thepatients as often as we would like we do rely on the nurses a lot in doing additional therapeutic techniques when we're not there...which I personally prefer thenurses to be doing rather than an untrained physio helper. because I feellvery strongly that physio helpers should not be doing the role of the physiotherapist unsupervised.I'd rather a properly trained nurse did some of the techniques than to send a helper up to do it instead, and I think it helps with the team approach as well if there is a certain overlap in who does what. just aswhen one of the nurses is very busy I frequently toilet patients so on to help them out and - this wasn't on Birchover but on one of the other wards - when they were very desperately short of staff I got some patients up for them onemorning because I could do a certan amount of physiotherapy techniques when I was doing that and it also helped them at the same time and I think it is important that we help each otherout when we're short staffed and things.

(Are there any areaswich you feel are not clearly defined in terms of responsibility - areas where it is not clear whose responsibility a particular thing is?)

I think that is one of the problems with primary care nursing - um with the traditional ward where you - say you were in a hurry and you

wanted to give some ~~particular~~ instructions as to how a patient should be handled you go to ~~the~~ Sister and she knows all thepatients and it's very straightforward. With primary care nursing sometimes it's not easy to find a member of staff that you want because they are only responsible for their own group of patients - you usually find there isn't any one person who is familiar with all the patients so when they're ~~xxxx~~ short, of when people are on holiday and they're covering other people'e patient groups they ~~probably~~ don't know very much about that patient and that can be a bit frustrating sometimes um - when you're trying to work out the techniques of treatment or whatever. They're not really very familiar with that other person's caseload but I don't see that as a particular fault of thoseparticular nurses - I think that's a fault of the system - it doesn't really allow for enough overlap particularly as they're trying to run it with ~~minimum~~ minimal funded establishment - it ~~gets~~ does make it quite ~~quite~~ difficult sometimes.

(Do you find it stressful at all?)

Y es - it can - it's stressful in that on a traditional ward you can go in and it's moreorganised and therefore you can get your work done more quickly - now that'snot necessarily what ~~we~~ you're aiming for - to get it done as quickly as possible but when you've got limited houss you do find it takes much longer to get the same amount of work done um on a primary care nursing ward than it would on a traditional ward - um because you have to appreciate that physio~~[illegible]~~ is only one of a group of things that is going on - um - it's not necessarily the most important thing that that patient does during the day - um - and therefore you sometimes haveto come second to the hairdresser, or the chiropodist or whatever - um - the patient has a sort of structured day - in that they have a say in what they do when and sometimes you find yourself fitting round other things ~~[illegible]~~ which obviously ~~so~~ is ~~that's~~ more time-consuming than being able to go in and treat the patient when you want

to treat them so it can be stressful from that point of view.
It's more time-consuming.

(The term - multidisciplinary clinical team - ~~i~~ comes up a lot. What do you understand by that term?)

Well it's one of these sort of in words - I still probably confuse multi-disciplinary with inter-disciplinary - um but to me either term means different disciplines working together with a certain amount of overlap of roles - whether that's the correct meaning I don't know but that's the way I interpret it.

(Would you say that there is a multi-disciplinary team on Birchover?)

I would say so - yes. Um - I think probably you could have more medical input - that's quite sparse - but I think the nursing and paramedical professions work as a multi-disciplinary team .

(So what's the - if there is a difference between everybody going in and doing their own thing, and a multi-disciplinary clinical team? What is it that makes a team ~~work as~~ a team?)

Because you're communicating more as to what you're doing and trying to complement each others activities ~~with that individual~~ for the betterment of the patient um the patient isn't being pulled in about six directions at once-you're trying to pull the whole thing together and work-instead of you ~~wanting~~ all doing your own thing separately and not liaising - you're liaising the whole thing together so it's much less confusng for the patient - you've all got the same aims-that's why we've got the multi-disciplinary meeting every week so we know we're all going in the same direction ~~with a~~ for each particular patient and I think that without having the team meeting ~~we~~ it probably would not work very well but I think that's where we all say ~~where~~ what

we're aiming for with that patient and we set down particular aims as to where that patient is going - what you're trying to achieve with them so that our skills are complementing each other. And - I don't think that necessarily works on a traditional ward um - because there isn't quite that same input.

Who makes up the multi-disciplinary team? Who would you expect to see?

Well, in this particular unit we've got a geriatrician, we've got a representative from each group practice of GPs, we've got the primary nurse, the ward nurse manager, we sometimes have our nursing officer present, we have the occupational therapist, the physiotherapist, the social worker um and we get invited people in - sometimes we have the district nurse coming - particularly if a patient is about to be discharged there might be problems when they go back into the community setting so they're invitied in, not necessarily to all the meetings - but when it's felt appropriate. So it's a fairly, there is a sort of basic team but then it is flexible - other people are invited in, other specialists - um, there's not reason why the speech therapist couldn't be invited in but I think it's lack of time - that's the only reason she doesn't come - so it's a fairly fluid arrangment - but there is a sort of core team.

Is there a leader?

(laughs)

Well, I think Dr. A[redacted] would see himself as the leader - I don't think the rest of the team necessarily see it that way - um I personally see nothing wrong in a leader because I think that um it helps to draw the team together um so I'm quite happy for him to be leader if he wishes to take on that role - it doesn't necessarily have to be him, but I think you do need a leader in a team um - to clarify what's going on - keep people to the point when discussing a case um - you know - I

think you need a leader.

Does it matter who the leader is?

No - I think it ~~expends~~ tends to be a doctor - but it doesn't necessarily have to be quite often if Dr. A[redacted] isn't pesent the ward manager — Sister R[redacted] will take on that role - that's quite acceptable.

Does the term key worker mean anything to you?

Yes - um, I think it's the term theprimary care nurses use for themselves - that they are ~~the~~ in the role of key worker and they are the chief liaiser between the disciplines.

Have you come across it used in any other context?

I believe social workersuse the term as well in the community - but it's not something I know much about.

Just thinking about when you've been working on Birchover - would you say that as a physio you were involved in planning the overall care of the patient, did you have any input into ~~planning~~ the overall care or were you really just planning ~~the~~ physio care?

Um - I would say yes because - that I would have planning in the overall care because we all do and I think that'sthe function of the case conference on a Tuesday - that is where we plan theoverall care and that's something everyone has input into. Um - so I don't think there is any one person ~~who plans~~ planning the overall care - but that is where the philosophy of care or the aims andwhat-have-you for that particular patient are discussed andagreed upon -it's a group decision as to where you should be going- and the overall care programme for that patient is agreed - agreed

objectives - at the Tuesday meeting.

(What happens if there is disagreement?)

(laughs)

There frequently is - I think that's healthy - um and I think that this is something that the primary nurses found quite difficult at first because they weren't used to standing up and airing theirown views and they felt a bit intimidated by it but now after we've been functioning for what - almost two years-um-they nowfeel a lot more confident and are prepared to stand their corner and say their bit and I think that's a lot healthier - um and I think also we all learn a lot from each other as w um - about different people'sroles - I personally find I learn a lot from the GPs about drugs which is something I am quite weak on and I feel free to ask questions if there they're discussing the drug regime for a particular patient I feel quite free to pipe up and say - what'sthat for - you know, what are you aiming to do with that so I think it's a great learning situation.

Can we talk a bit about care? What does the term 'care' mean to you?

(Pause)

You're talking about patient care?

Y es, care of the elderly - make it as general as you like - you mentioned just now philosopy of care - with a particular patient - do you have a philosophy of care? What do you mean by care?

(Pause)- I belive in quality of life - and I think that's something that's always at the back of my mind when treating any patient that whether elderly or young I see it as part of my role to improve their quality of life - um and this can be helping them to live with a disability-um - or in some cases taking an active part in curing a problem - or sorting out a problem for them - um, that would

be my phsilosophy of care I think. A total sort of concept.

Do you feel that this is the same ~~that~~ philosophy that the nurses on [redacted] have ~~[illegible]~~ - or that ~~[illegible]~~ nurses in general have

(Pause)

I don't think nurses in general - and I don't think that's a criticism of nurses necessarily, um, I think that sometimes - and I think it's very much a criticism of doctors sometimes that um - and physios, that sometimes you get very bogged down in treating a particular problem, rather than ~~and not~~ looking at the whole patient and I think with the primary care nursing philosophy and multi-discilplinary and what-have-you I think we do all look at the whole patient and not just a part of that patient. I think that's oneof the bonuses of that system. I think it makes you have a broader outlook.

Do you think it matters if nurses andphysios who work together don't share common philosophies about care?

Um - well, (pause) it's difficult really because I think, you know, it's bound to happen, it's not an ideal world - it's different personalities, you get a group of physios working together and they don't all think the same way so you can't really expect different disciplines to. I think it is something that has very much developed on that unit. I think we probably did all have very different ideas ~~[illegible]~~ to start with and I think we've grown closer together as the unit's developed. I think that's one ~~[illegible]~~ of the bonuses, that that has tended to happen. I notice that when someone new joinstheunit that - they might be a little bit stereotyped to begin with and they sort of find it all a bit sort of unnerving and this applies to anybody when they first join theunit. and then they gradually fit in with the philosophy ~~of~~ total care. I'm not really answering the question - I'm doing my best! (laughs)

Could I ask you a bit about yourself? Where you trained and what other jobs you've had?

I trained Newcastle RVI which isnowat the Polytech. Um - between about '69 to '73. I was a bit of a slow learner - struggled with Physics.

Didn't we all!

I nearly got thrown out! But managed to stay on. And then I worked at a small hospital very similar to this job - which was my local hospital. How much detail do you want me to go into?

(interviewee had already indicated she would have to finish at 2pm as patients coming - was concerned here - looked at watch)

Well I want to know about yourrexperi nce - we'll stop in five minutes.

Quite a similar set-up to this hospital really - there were some part-time physios - there were more staff than there xare here. There was a Superintendent physio, there was me - a basic-grade, full-time and I had to sort of deputise for the boss - so I've always been quite keen on taking on responsibilities I suppose. I did that for fourteen months because I'd ~~and then~~ decided that I wanted to go and work in Australia - my chief interest at that time was neurology - ~~I~~ I've always enjoyed treating stroke patients particularly, and I've an interest in Parkinson's disease and so on as well. And this job came up in Australia with the Multiple Sclerosis Society which was not only MS but lots of obscure neurological disorders ~~which~~ and I thought it was a great opportunity to learn and it wasa lot more money so I could travel. So I went out there, worked for three years - the first year I was the junior physio, then my boss, the chief physio left to develop her private practice and I wasinvited to take charge of the unit - which was quite small - it was a private clinic with day patients coming in - but we also owned two nursing homes as well so again I had an interest in elderly as well, ~~like~~ as I had in my first job - there was quite a lot of elderly - similar to here. And so I had to implement

service into the nursing homes - as well as treating thepatients on the unit - um - then I did a couple of locums before coming back to this country - and then decided that my second interest really had really always been orthopaedics - I felt I had specialised in neuro for long enough and that I needed to branch out a bit more so I got a job at Princess Margaret Rose which was implementing a service on a geriatric-orthopaedic unit which I really enjoyed.

This was in Edinburgh?

This was in Edinburgh, but there wasn't - it was only a small unit so I was also given some consultant work to do aswell, back disorders - a consultants doing cold orthopaedics and leg lengthening procedures as well, so it was an interesting job because there were two quite separate parts to it. I worked there for just over five years - got married - came down here - got divorced - when I left my husband this job was going and I thought it sounded as though it had potential because of the developments in the area - so I came here.

So what particularly attracted you to here?

Um - well I felt it was - at the time I was feeling a bit under par - I had had quite an emotional bashing and it was something I felt I could be on top of fairly quickly - so basically it attracted me because I felt it wasan area I had quite a lot of experience in and could walk into - fairly easily but also the fact that there were obviously new developments in the offing although at that timeitwas all rather vague but it was mentioned that the hospital wouldbe expanindg and I thought that sounded interesting and the fact that there was going to be a new physio department - I found that interesting - the thought of developing it you know, implementing new services and so on. so I felt it was a job I could handle immediately but a job with potential - it was going somewhere.

Right - we'll finish there.

(Interview terminated due to time constraints - patients arriving - arrangements made to go back and finish it the following week.)

We finished last time by talking a bit about you and what you've done so far ... so if we can just go on to relationships between nurses and physios ... now some people think there is conflict between nurses and physios. Now while relationships here are obviously good can you see any potential areas of conflict?

Well there have been - you probably know, there have been areas of conflict in thepast - I think we have been adult about it - I personally had quite a lot of conflict with the nursing sister which I think was basically a personality clash, um - there were lots of rows but I think we have now a healthy and probably a lot more honest relationship than we had before - it was something we had to work through - we're very different types of people - and you know we sort of solved that one - I think there are bound to be certain amounts of conflict in primary care nursing the nurses are getting ~~xxxxxxxxxxx~~ used to a new sort of role and at first they tried to do everybody's job for them - I think that's what primary care nursing encourages them to do - then they realised that obviously we've got a lot to offer too and we've learned now ~~xxxxx~~ where the boundaries are but having said that it's not distinct boundaries as to who does what -there's a lot of overlap but it was an understanding we had to come to - so that we knew how far to go in each direction. It was hard in the early stages but the multi-disciplinary team approach encourages that - I think if it was primary care nursing on its own I think we would have been pushed out my impression of the Burford unit is that physio and OT don't have much input. I think that's partly because of staffing levels down there - they're only part-time anyway and they certainly don't work in the same way we do here - as you know this was based on what they do at Burford we modified it as a group - so I think with primary care nursing there's a lot of potential for conflict - perhaps more than in a traditional nursing-physio relationship.

Can you be a bit more specific about the issues that might give rise to conflict?

initially wehad a lot of difficulty in deciding how we were going

Um - initially wehad a lot of difficulty in deciding how we were going to record the notes - where we were going to record them - um - and we weren't reading each other's notes - we were all doing our own thing - which just wasn't working as a team - ~~lots~~ we tried lots of different combinations and finally tried what we have now where we have all the notes together, separate from the doctor's notes but all the paramedical notes together and I think that now means we do - certainly we now have the opportunity to read each other's notes a lot more - whereas if they're all stored in different places you tend not to bother. So that was something - that took a lot of working out - to get a system that worked for all of us - that we were all happy with - we had to thrash out things like - originally I worked out a sort of functional assessment which I thought that the nurses could probably do with the patients - the primary nurse - and that would highlight sme of the physio and OT areas which we would need to home in on - coming in probably at a later stage because the primary nurse gets to know thepatient moreintimately than we do - being on theward for only a short time of day - that fell by the wayside - they weren't really interested in that - x I have used that sort of system before and found if effective so I found that a bit frustrating but it had to be a majority decison um - so we would work through quite a few different problems to get to the stage we're at now and it probably took about six months to build up a good relationship.
(Pause)-Have I not answered the question?

I'm just waiting to see if you've got more!

What about uniforms? Was that an issue at one time?

Y es, initially, what they did at Burford was - I don't think this involved the para-medicals but I might be wrong there - the nurses had this new uniform - they all decided they had to be in the same uniform so that the philosophy didn't make sense to me but the idea was that although it was a uniform it meant thatyou couldn't be identified one from the other - that everybody should be the same but having said that you're not going to look like the patient's visitors anyway - they're going to be in their own clothes - when visitors come in they're not going to be able to identify who's in charge of theward - who to speak to - they don't know who the primary nurse is - no differentiating uniform - and they might particularly want to speak to thephysio or OT or whatever, and all other hsopitals we all do it - we all differentiate people by what they're wearing I think that's quite important because it makesit easier for the people coming in um - I know I find it easier when I walk onto a strange ward to see who people are - their theory was that it was too institutionalised and they didn't like it - now Burford I think decided not to have uniforms at all - that was it - that's right and the general public kicked up a fuss and they had to go back into uniform - traditional uniform - so they went full circle - they thought about mufti here and most of them weren't keen on it so they decided to have one uniform for everybody, then it got changed and they decided they would have one uniform for trained staff and one for untrained and I was supposed to go into the one the trained staff had - I felt that I couldn't afford to spend - waste - two thousand pounds equipping my staff with new uniforms - there were other more pressing things to spend mone y on so I refused - I was pressurised quite strongly by T[redacted] in the beginning to wear white trousers I think it was and I said no way - not when I'm doing out-patients as well - it was ridiculous - totally impractical - um the OTs did go into it to start with and then I think a lot reverted back to their old uniforms, the radiographer flatly refused as she wasn't going on to the ward anyway, so, yes the nurses

went into a new uniform which they have since changed yet again - the sisters had - first of all they all had the same, then they had a different one and nowthey've got a different one again - all in all a lot of money hasbeen wasted - which I feel quite strongly about. That's it - in a nutshell.

How was the issue resolved in the end?

Um - well basically we're back to square one - although it's a different uniform it's a different one for the sisters, a uniform for the staff nurses who are the primary care nurses, and a uniform for the auxiliaries and paramedicals wear their normal uniforms - so we've really gone full circle back to where we started. And I don't think any of them wanted to work in their own clothes, with the exception probably of Sister Ratcliffe who isthe ward manager she wears her own clothes because except for when they're pusehd she doesn't have that much clinical input.

Why do you think people wear uniforms?

Well personally I think we were told a lot of claptrap when we were down at Burford Unit about it makes you feel big and it makes you feel important - that's not why I wear a uniform - i wear a uniform because I do not like spending a fortune on clothes - it's not a high priority for me - I do not wish to wear my own clothes to work because then they would become work clothes and I would have to have another set of clothes for at home - it's convenient, it's easily washed - it's durable - it's practical - and that's why I wear a uniform - I don't need a uniform to make me feel important.

Why do you think it became such a big issue?

Personally - I don't know but I do know that they spent a lot of time talking about uniforms and in the early stages of that unit evolving we should have been getting down and ~~xxxxxxxx~~ sorting out our multi-disciplinary team. I did mention this once or twice because I felt that would be the key to success or failure of that unit and all they could think about was what uniforms they would wear.... which I thought was very low down on the list of important issues.

(So it was an important issue for them?)

For them but not for us - we couldn't understand all the fuss about it.

(Now people talk quite a lot about handing over skills. In terms of you handing over skills to nursing staff - how do you feel about that?)

Um - I don't feel threatened by it. Because I believe in sharing skills - obviously up to a point - we have certain legal rules and regulations - we're not allowed to let other professions do - electrical techniques and so on that they're not trained to do - but I think it is important that we do share our skills so that we work as a team particularly as we don't have any weekend cover here. It's ridiculous to think you can just do the physio five days a week - you've got to share our skills so that you can get continuity of care. Um - and I think it is a very individual thing - I don't sort of say oh yes the nurses can do all of such and such - we work it out with each patient - each patient's programme - and certain skills are shared for that particular patient. It's not a general handing over of skills um - one specific thing wouldbe the positionzing of stroke patients I feel it's very important that that is continued when we're not around and that's something the nurses are quite capable of doing -we've got charts up - you just have to follow the charts. And that really makesour

job a lot easier when we come back in on a Monday - if we've got a stroke patient who's developing spasticity - so it certainly helps the team approach if we share skills and helps the patient ultimately recvoery. That's just one example of the things we do - do you want some more?

If you've got some, yes.

um - likewise I don't feel I'm too important to toilet patients etc. for the nurses and in times of stress and severe staffing problems I've been known to get patients up. If they're happy for meto do that then I'm happy to help if I've got time to do it. Um - home visits - that's something we share not so much with the nuses but with the OT it's very much a joint thing - sometimes the nurse will come along but not very often but that't entirely her choice.

Is there anything else you feel that as a physio you can teach the nurses? Any particular skills?

Well I think I mentioned previously that I feel very strongly about lifting and handling - and that's something that I've made a point of doing - regular sessions which started off quite enthusiastically and then they sort of tailed off because with staff shortages they found they couldn't actually spare the staff to come to have a formal talk - I talk about back care - and get the skeleton out and talk about backs, handling techniques, and also the fact that different people need different things - it depends how tall you are - how strong you are you need to modify techniques to your own personal use - I feel very strongly about different nurses tend to be taught stereo-types techniques and if you get a tall nurse and a small nurse trying to work together using an Australian lift which is clearly unsuitable for the two people involved and I don't think that's really been gone into before. I try to teach them on a more individual basis - teach them some basic transfer

skills and then encourage them to modify them in different situations to their own needs and to the needs of the patient. Now recently I've been having to just do individual sessions because of the staff shortages but it's still going on and they know they can come to me and they do cometo meon the ward and say look I'm having trouble with this particular patient - can you help us - show us how to handle them so that's omething that I personally as a back sufferer that I feel very strongly about. And It's a skill that we must share with everybody.

Is there anyghing you do - in your work on the wards - that you really think is the nurse's job?

I think things like taking temperatures - taking blood pressure - if I come on and there's a new stroke patient in and I say is this - can you tell me if this patient's blood pressure stable enough for us start doing physio - I would not go in a take that patient's blood pressure myslef because I would feel that that would be encroaching on their territory - um, just as I would not start spouting off about what drugs the patient should be on - I don't feel competent to do that - if somebody's got a lot of spasticity I might sort of say well you know perhaps a small dose of valium might help me to do my physio but on the whole I feel that things like that are much better understood and that the nurses have much more knowledge than I do - certainly it's something that we discuss - I'm certainly eager to learn about what different drugs do - but on the whole that isone area that I feel the docos and nurses are far more competent in and that I don't have a lot to offer personally - some physiosprobably know more about drugs than I do - and that's one of the things I mentioned previously that in the case conferences I'm keen to learn more about these things that you haven't had asmuch training in as others.

Do you ever find yourself doing something you really feel the nurses ought to be doing?

Sometimes - only if - if there are a lot of nurses standing around which does happen - particularly the untrained nurses - occasionally I'll go on the ward and I know I've only got two hours to do a certain number of patients and none of the beds are made - and you want to lie a patient on a bed to do certain procedures and first you've got to set about making the bed, to put them on it. Now, if the nurses are running about like scalded cats I do not feel upset about it at all but if there's a lot of people hanging about then I do feel annoyed that they haven't done them for me, because I don't feel I should be wasting my time doing that particular thing in that situation. So that's probably about the only thing really which bothers me. Perhaps the toiletting as well - you know, if they're obviously not busy - um I think it's with the merging of roles - I feel it's nice to be able to help each other out in a crisis or when you're short of staff but there are certain roles that they ought to be getting on with - I mean the idea is to make each other's job easier - not to expect me to be doing some very routine tasks, that ought to be done by the auxiliaries.

Such as?

Such as making beds. I often go on that ward at 2 o'clock and none of the beds are made - um - and there will be sort of 2 or 3 auxilaires hanging about doing nothing - I think that's unnecessary -

I think you've partially mentioned this - answered this next bit - but I'll ask again and see if you've got anything else to add.. it's about professional skills - what do you think nurses areparticularly skilful at doing - you'vealready mentioned bloodpressures, drugs ,.. if you could think a bit moreabout what makes nursing skilful -

I think it's important for the patient to havetime - that is the thing that we don't have in this department - we do not have enough time to

spend with the patients - either out-patients or in-patients - it's not something I havemuch control over - until we've got a greater staff input - which I'm pushing for but that's something I'm aware of - they're one up on us as they're on the ward all the time and they've got the timeto build up a relationship with each patient I'm quite envious of that actually because I would like to be in a position to do that and it's only when the ward is quiet that I feel I can really get to know the patients as individuals ... so I feel that'ssomething they do better... at the moment than we can. I also mentioned about different expertise - drugs and so on. I'm not quite sure what you're driving at -

(It's not an easy question - what is it about nursing that makes it nursing? What is it that the nurses do that you as a physio can't do?)

Um - well I suppose the general caring - TLC if you like - um - (pause) well things that are specifically nursing skills - sorting out their problems - bowel problems - where we just don't get involved. There are things likeincontinence where again it's a joint thing - but they would do two-hourly tioletting - and we would be doing pelvic floor work or sometimesix interferential as a combined thing. There are things like pressure sores where I think they haveparticular expertise in the dressings and I've got the expertise in the electrical treatments but there are if you like divisions between who does what - although some physios wouldn't agree with that and the would want to do the dressing as well but that's the way we work in thisparticular unit. What other things? Um - doing little things for the patient - make phone calls for them - sort out their domestic problems - patients worry about having bills paid and things like that - it's the nurse that they probably talk to and she brings in a social worker if necessary or sorts it out herself. Things like knowing about the residential homes - the

nurses have more intimate knowledge of what's available and what's suitable for the patients than we do - and that'spartly because I'm not able to visit as many of the homes as I would like - again a lot of it boils down to time. I think there always will be specific areas which they cover that we don't cover... that I don't think we should cover. Um - blood pressures, temperatures, giving out drugs, all the traditional nursing skills .

What do you think physios areparticularly good at doing - what can they do that nurse can't or don't do?

I think particularly working with stroke patients - I think if there isn't good physio input into stroke patients then it's disastrous. I think anything to do with mobility and again it's abviously a matter of training - you can't expecta nurse to assess a patient for a walking aid as a physio would - they haven't got thebasic background knowledge they would just tend to throw any old Zimmer at anybody whereas we know about whether that particular Zimmer's appropriate, what height it should be etc. etc. so we've obviously got more expertise andthe results are better than if you just let the nurses do what they think. Um - we've got expertise with the bed sores asI said but I think it's a joint programme - I wouldn't be expecting the nurse to be applying things like Kromayer or Ionozone or any specialist techniques that we use because we'vebeen trained to use those things and I don't think they do Physics in their training - so they just haven't got the knowledge and legally they can't do it anyway - basic training. I think - I was discussing this with a friend at the weekend who is working on a neuro unit at the moment - this business of the nurses' intelligence - which is a very sticky area - we've both found on two entirely different units that we run up against a sort of stumbling block, particularly in neurology - that you can only teach them so much about things like pooitionaing and things like that - I've

found that I've had to keep the neuro things very basic - because they simply do not understand neurology - but I think that's probably something to do with training... or lack of - they don't - I think on a ward where - on orthopaedic trained nurses are excellent on orthopaedic matters but I don't think on a general unit like this I findthat they are woefully ignorant about the most basic orthopaedics - such as if somebody's had a hip replacement & positionaing them correctly so they don't dislocate - things like that - but again those are areas where we need to get together on and I feel I have a teaching role to play. But even when you do teach them - just this morning - yet again a stroke patient who has a sub-cuff on - with a sub-luxing shoulder which is really painful was hauled up the bed by his shoulder. Now that's - I've told the nurses about that numerous times and I think they just forget they forget howimportant it is - I think that's probably because they don't have the backgroundknowledge to go with it - it's just something we'vetold them that's a bit meaningless to them because they don't understand why it's important - perhaps that's our fault but we keep explaining and explaining and these things still happen. Even - I mean we've had problems with such basic things like tubi-grip which we have graduated tubi-grip which is narrower at one end than the other now if we've got somebody with lower limb oedema - I always tell them to put a graduated tubi-grip on because obviously it's going to be more effective than a one thinkness one on that will drive all the fluid down into the foot - an obvious thing that I would have thought any intelligent nurse couldunderstand - and again and again they make the same mistakes - which can be very frustrating - the information doesn't seem to get passed on from nurse to nurse. They'll put on one that's the same size all they way up when we've made sure they've got supplies of graduated tubi-grip - and to crown it all I had a Seton rep in the other day who said - about doing dressings on gravitational ulcers in the community - oh we never use those she said - the community staff can't get thosebecause they're too expensive - we use the other kind - and I walked out in disgust - I thought there's no reason at all why

they can't use them - a well applied crepe bandage would be more effective - than doing something which you know is wrong. So obviously we have these sort of problems but we just have to work through them - just have to keep trying and trying and trying.

Right - now the last little bit - I've goth three conditionswritten down here - you have mentioned all three of them already so there's nothing horrendous about this - I just want to - and this isn't this is NOT exam time -

It's felt a bit like it this afternnon!

That's because I didn't do the introductory bit to reassure you - I shall haveto remember that if I do a split interview again - to do my introduction again - it's what YOU think about thisthat is important not whether it is right or wrong. It's your feelings or your thoughts about it that isimportant. What do you think physiotherapy can offer that nursing can not in the following conditions - incontinence - What's physiotherapy got to offer in the management of incontinence?

Okay - so granted we're working together on the team - but I think specifically we are the ones thatunderstand how thepelvic floor works and how to strengthen it and I think that's our major input - the pelvic floor exercises and making the patient aware of what theirpelvic floor is and if necessary using interferential or any other menasto stimulate it. Um - I think the regular toiletting is something that the nurses are in a better position to do because they're with thepatient all the time so again it s a combinedprogramme - I think we do thepelvice floor side specifically. (Pause) That's it really.

Pressure sores - what do you thin physiotherapy has to offer that nursing cannot?

Again I think it's not a thing one profession does on it's own - I feel very strongly it is a team approach and I think that physio offers - um - well this is a personal view - I don't think I'm the expert at cleaning up the ~~xxxxxxx~~ wound - I think they're better at that - I think they're better at finding dressings - I think where I come in is to stimulate granulation either by using the Kromayer, Ionozone, or whatever electrical technique - I think when the nurses have got a nice clean ulcer and the thing is indolent, I have a role to play indoing ultrasound to try and speed things along - and any of these electrical techniques obviously it is appropriate for physiosto do because we're trained to do them - also I think the exercise is not necessarily physio - I think once we've discussedit the nurses are quite capable of making sure thepatients do them regularly - the actual dressings I don't think are a particular physio thing - occasionally I recommend using a Disgaard bandage - they're going out of fashion these days but I think that can be something that is better if we apply that - to get the tension right. Um - that's about it.

The third thing was leg ulcers - but most people have - although I have ~~xxx~~ separated them out but most people have done what you did and discussed pressure sores and leg ulcers together - is there anything more you wanted to add about ulcers?

Um - no - I haveto confess it's not an area I feel personally I have a lot of expertise in - so I don't haveparticular strong views on it.

You mentioned exercises - can you just talk a bit about that?

In relation to pressure sores or ?

And leg ulcers.

Well with thepressure sores I think it's really not so much exercises as such for a sacral sore - I mean obviously encouraging he patient to be ambulant basically andxxx there again I rely on the nurses to carry that through - but with a leg ulcer then yes - dorsi-flexion, plantar-flexion, general leg exercises as well as the walking. But I see these as fairly basice types things which we initiate and they continue.

What do you think the nurse have got to offer in these conditions which you haven't?

I think they have a lot more expertise about cleaning these thihgs because I don't think it's something I have got expertise in - most nurses have but I haven't - so I'm only too happy for them to use sea-weed dressings and anything the like because I think they know more about it than I do - I'm interested in what they're doing - it's not that I just wash my hands of it - and I get them to discuss it with me because I'm eager to learn but I fell it's their role to do that side of it -the dressing, the cleaning, preparing the patient ready for physio treatment that might be necessary - um - and generally monitoring - I'm quite happy for them to measure the size of the sore but I can then look in their notes andsee how things are progressing. And vary my treatment according to their findings.

Right - isthere anything you want to add to what we've said. Anything else you'vethought about ?

(Pause) Well I'm pretty aware of some of my own faults - I have been told I have a short fuse - but having said that some of the nursing staff in this hospital I would consider close friends - I think generally speaking when I'm not under severe pressure a lot of the time which happens to us all - I'm pretty easy to get on with. I don't suffer

fools gladly - but as I say I have developed what I think are good relationships with some of the nursing staff and I feel that's something positive that comes out of this system - that I think perhaps it has encouraged us to work more closely together - and also have a greater respect for each other's skills... which I think is something that in the past hasn't alwaysbeen the case because I don't think in other ward settings you intimately understand what each other has got to offer - because you're force to work so closely together and you're continually - with the case conferences every week you're continuously monitoring what'shappening - you find out very quickly what does and doesn't work - and you have to be very honest in your relationship with nursing staff andnot make out tha physio is some magical cure for everything - they soon find out what works and what doesn't work and I thin kit encourages a very close working relationship.

Thank you very much.

You're very welcome! It's a load of bullshit!

Appendix G

Definitions of Physiotherapy 1974 - 1996

Curriculum—Aims and Objectives

PHYSIOTHERAPY is the treatment of injury and disease by physical means. It is used to help patients to regain and increase their physical abilities, to give them the opportunity to achieve their maximum potential in activities at home, work, and leisure.

THE OBJECTIVE of physiotherapy training is to produce a professional person with particular therapeutic skills and sound theoretical knowledge.

The therapist will require certain innate characteristics. Sympathy, sensitivity, and firmness must be combined with keen powers of observation, objective judgment, and enthusiasm.

The rehabilitation process is often demanding for patient and therapist. Physiotherapists must possess stamina and be physically fit.

The content of training on pages 2–20 indicates the range of subjects to be covered. The levels of learning required will be indicated to the student, as the course proceeds.

The physiotherapist should:

(1) have a knowledge of the basic facts and theories mentioned in the syllabus, and be able to understand and explain them;

(2) have acquired an acceptable standard in the performance of basic skills, methods, and techniques of treatment;

(3) be able to examine and assess a patient by recognising deviations from the normal, and keep adequate records;

(4) be able to select, plan, and progress a treatment programme;

(5) be able to make professional judgments and communicate effectively with professional colleagues, patients, and relatives;

(6) gain an insight into medical research methods as a basis for further study.

1974

Chartered Society of Physiotherapy
Curriculum of Study

Syllabus of Studies

Anatomy and Physiology

The study of structure and function should relate the practical application of anatomy and physiology to physiotherapy wherever possible. The emphasis should be on the living and functional aspects of these subjects rather than on unessential detail.

A physiotherapist must have an understanding of the normal development of the human body in order to be able to differentiate between normal and abnormal patterns of movement, a knowledge of which is essential in the assessment and treatment of patients.

The student will be expected to demonstrate knowledge and understanding of the following.

LIVING ANATOMY

To identify by inspection and palpation bony features, tendons, ligaments, joint lines, muscles and nerves, pulsation of arteries.

To indicate on the surface, structures which will include the course of nerves, chief blood vessels, and lymphatics.

To identify the position of:

(*a*) the heart, including the apex beat;
(*b*) the lungs, including lobes, fissures, and broncho-pulmonary segments;
(*c*) general position only of abdominal viscera;
(*d*) main lymph nodes.

To apply knowledge, in order to understand:

(*a*) the range of movement normally present in all joints, including any accessory movements;
(*b*) muscle actions, individually or in groups, and their functional use;
(*c*) the distribution of nerves – including dermatomes and myotomes

HISTOLOGY

The cell:

(*a*) its structure and principal constituents;
(*b*) main properties and functions including cell division.

The structure and functions of epithelia.
Structure and functions of connective tissues, including ligaments, tendons, aponeurones, fascia, and cartilage.

In outline only:

Normal physical development:

(*a*) *the main events occurring during the gestation period;*
(*b*) *growth from birth to maturity (especially of nervous and locomotor systems).*

THE CURRICULUM OF THE CHARTERED SOCIETY OF PHYSIOTHERAPY

THE ROLE OF THE CHARTERED SOCIETY OF PHYSIOTHERAPY

In 1920 under Royal Charter The Chartered Society of Physiotherapy (CSP) was established as the sole recognised examining and professional body for physiotherapists in the UK enabling it to:

> 'Promote a curriculum and standard of qualification for persons engaged in the practice of massage, medical gymnastics, electro-therapeutics and kindred methods of treatments'
>
> and
>
> 'Make and maintain lists of persons considered to be qualified to practise in such methods of treatment.'

The 1960 Professions Supplementary to Medicine Act established a statutory state registration Council (CPSM) which recognised qualification for membership of the CSP as a condition for entry to the state register.

The advent of degree courses in physiotherapy has also led to a tripartite system of course approval between CSP, CPSM and CNAA with the CSP's 'Guidelines for Approval of Courses' being used as the standard by which professional content and methods of assessment can be ascertained.

The year 1984 has seen the publication of draft EEC directives on Pre-Registration Physiotherapy education. The CSP has played a full role in the discussions which are part of the Society's wider international educational activities.

What is Physiotherapy?

The CSP considers that the practice of physiotherapy is dynamic and evolving and that any definitive statement would be restrictive. While the following definition is useful in the current state of development it is not intended to be all inclusive:

> 'A systematic method of assessing musculo-skeletal, cardio-vascular, respiratory and neurological disorders of function including pain and those of psychosomatic origin and of dealing with or preventing those problems by natural methods based essentially on movement, manual therapy and physical agencies.'

Aims and Objectives of Pre-Registration Education

The aim of Physiotherapy pre-registration education is to produce safe, effective therapists who have adopted a rigorous academic, scientific and ethical approach to the acquisition and application of their knowledge and skills for the benefit of their patients. Once qualified the therapists will maintain their education and develop their skills further.

The objectives of pre-registration education are to produce a physiotherapist able to:

DEMONSTRATE a knowledge of, and an ability to apply an investigative approach to, academic and clinical subjects;

ANALYSE and ASSESS the physical, psycho-social and environmental state of the patient from a physiotherapeutic point of view;

SYNTHESISE knowledge and assessment of the patient to identify treatment objectives;

PLAN a therapeutic programme for each patient to achieve treatment objectives while recognising the involvement and priorities of other members of the health care team;

IMPLEMENT that programme with the maximum degree of safety, effectiveness and efficiency;

EVALUATE the effectiveness of both assessment and therapeutic programme; and vary the programme as necessary to meet revised objectives according to the patient's progress and potential for recovery;

PROMOTE positive good health and prevent disease and disability through education programmes directed at the general public, specific target groups, patients and families;

TEACH and ADVISE patients, relatives, medical practitioners and other members of the health care team on the physiotherapeutic management.

A newly qualified physiotherapist will normally spend at least two years in a hospital-based rotational post, working under the supervision of senior physiotherapists, before undertaking independent clinical practice and moving into a specialist field.

Curriculum of Study (1984) CSP

SECTION 2

DEFINITION OF PHYSIOTHERAPY

Physiotherapy is a health care profession which emphasises the use of physical approaches in the promotion, maintenance and restoration of an individual's physical, psychological and social well-being, encompassing variations in health status.

- The core skills used by chartered physiotherapists include manual therapy, therapeutic exercise and the application of electrophysical modalities. Through problem-solving and clinical reasoning approaches, the physiotherapist is able to apply these skills appropriately in response to the varied needs of individuals.

- Chartered physiotherapists work with individuals and are involved in the management of a broad range of physical problems, in particular those associated with the neuromuscular, musculoskeletal, cardiovascular and respiratory systems.

- The assessment and evaluation by chartered physiotherapists of an individual's needs, or potential needs, take account of the current psychological, cultural and social factors and their influence on the individuals' functional ability. This encompasses the needs of associated carers.

- Through negotiation and partnership, chartered physiotherapists work with individuals with specific needs in order to optimise their functional ability and potential.

- In addition to a general role in promoting health and the prevention of problems, physiotherapists have an educational role in promoting self-care. This can also extend to advising and teaching associated carers and other health care professionals in order to provide a coherent approach which maximises independence.

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SCHOLARLY PAPER

Theoretical Models of Physiotherapy

Pennie Roberts

Key Words

Physiotherapy, theoretical models, medical, social model, holism.

Summary

The origins of the physiotherapy profession, in particular its relationship to nursing, are examined. The rise of medical dominance in society is related to the medical dominance of physiotherapy and the implications of this on the development of physiotherapy theory. Three theoretical models cited in the literature are examined in detail — the medical model, the social model, and holism — and the implications of their adoption as a basis for physiotherapy practice is discussed. The close relationship between the medical model and physiotherapy is examined and an argument made that before the profession decides to abandon it as a basis for practice the implications of that are understood and debated. The danger inherent in adopting any existing model as an alternative is addressed, and the third option of developing a physiotherapeutic model, unique to the profession, advocated.

This paper has been developed from a shorter paper presented at the international conference 'The Science and Art of Physiotherapy' in Hong Kong in July 1993.

Introduction

Recent literature related to health and health care, including physiotherapy, makes frequent mention of the medical model, the social model and holism. The medical model has been discussed in terms of its appropriateness to physiotherapy by Mason (1985), Williams (1986), Pratt (1989), Sim (1990), Condie (1991) and Parry (1991). Suggestions have been made by these authors that the medical model may not be the most relevant conceptual framework for physiotherapy practice. In an attempt to offer alternatives which may be more relevant French (1992) and Johnson (1993) have begun to explore the relationship between the social model and physiotherapy. However, little has been written exploring the concepts and beliefs underpinning holism and their relevance to physiotherapy practice. What is clear in these writings is that the search is on for a theoretical model other than medicine upon which to base physiotherapy.

This paper discusses the relationship between the medical model and the historical development of organised physiotherapy since 1894, and questions whether the medical model as a basis for their practice can be cast aside easily by physiotherapists. It explores the beliefs underlying these three most often quoted models — the medical, the social and the holistic — and examines why adopting the latter two as alternative frameworks within which to practise will require a radical rethink of the practice of physiotherapy.

The importance to the profession of developing an understanding of the theoretical concepts of different models is that accepting or denying a relationship between practice and a particular model involves accepting or denying the beliefs that make up that model. Without an understanding of the beliefs or concepts that underpin available models an informed choice cannot be made, either by the individual practitioner or by the profession collectively, as to which is appropriate for practice. A gap in physiotherapists' understanding of theoretical models is matched by a gap in the profession's understanding of its own theoretical knowledge base.

Origins of Physiotherapy and the Nursing Connection

A review of the literature shows that little has been documented about the development of physiotherapy, or physical therapy, before the last century. However, the practice of something which we would all recognise as physiotherapy is mentioned in ancient texts. Massage, manipulation and exercise therapy all appear to have been valued as healing arts (Pratt and Mason, 1981) practised by women in the communities in which they lived (Ehrenreich and English, 1974; Versluyen, 1980; Sjoo and Mor, 1991). The rise of organised medicine as a male dominated, centralised hegemony during the 19th century (Abel-Smith, 1964; Friedson, 1970 a, b) meant other health care professions had to react to the pressures created by this powerful group and either submit to the dominance of medicine or face exclusion from mainstream practice with subsequent loss of respectability and earning power.

The emergence of a professional body in the United Kingdom, the Society of Trained Masseuses — later to become the Chartered Society of Physiotherapy — has led some to claim that physiotherapy emerged from nursing. However, the women who founded the Society of Trained Masseuses, while having nursing backgrounds, were interested in developing and regulating not nursing but physiotherapy. They formed a professional association dedicated to the promotion of good practice in a profession which was something other than nursing. The problem with tracing the origins of physiotherapy back to 1894 and no earlier and therefore to its nursing links is that this legitimises nurses' claims that they as a profession should reclaim those skills which they allowed to be taken away from them by this new profession of physiotherapy. Physiotherapy was not in 1894 a new profession. The professional organisation was founded in 1894 but not the profession itself. Physiotherapy has many roots, some contemporary, some going back into ancient history. Mason, in his series of articles recording a number of historical elements of practice, is reporting on the origins of a profession that has eclectic roots, many of which are certainly not common to nursing (Mason, 1992/4).

One result of the emergence of the newly organised professional organisation of physiotherapy from the practice of women who were also involved in nursing and associated disciplines was the availability and proximity of prominent medical men to whom to turn for advice and support. The relationship between the dominant health care model — the medical model — and physiotherapy can thus be traced back to the formation of the Society of Trained Masseuses.

The Rise of Medical Dominance

The history of physiotherapy in the United Kingdom within the regulatory framework initiated by the founders of the Society of Trained Masseuses is a history of medical patronage and dominance (Wicksteed, 1948). The founders of what was to become the Chartered Society of Physiotherapy traded professional autonomy for the respectability offered by doctors.

This control was less evident in the early days of the Society of Trained Masseuses but grew as the profession of physiotherapy became more organised, more influential and more successful. By 1920 the professional organisation had developed to such an extent that a Royal Charter was granted and for the first time a non-physiotherapist — a doctor — was elected chairman. It was to be 52 years before the chairmanship was resumed by a physiotherapist. The dominance of the professional organisation was not just through the figurehead of the chair of the elected body; it is noted by Wicksteed that:

> 'At important meetings and on deputations to public bodies, such as the War Office, National Insurance authorities, etc, the Society was always represented by one and sometimes two medical men who were even, on occasion, unaccompanied by any elected member of Council.'

Wicksteed explains and justifies the policy of accepting medical patronage to advance the profession because of two factors, one being the struggle for recognition as a professional body working in close co-operation with the medical profession and therefore reliant on its goodwill, the other being the lack of interest in the organisation shown by the majority of members.

The pay-off for the doctors was of course the subordination of an emerging profession which could otherwise have posed a threat to their own dominance of health care (Friedson, 1970a; Larkin, 1983). The pay-off for physiotherapists was the patronage of one of the most powerful groups in society. While the hegemony of orthodox medicine was at its most powerful, physiotherapy gained from an alliance with doctors, albeit in a subordinate role. However, doctors also dominated the practice, the management and perhaps, most significantly, the theory of physiotherapy (Miles-Tapping, 1985; Sim, 1990).

'The Doctor of Physick' from an early manuscript of Chaucer's *Canterbury Tales*. Scientific medicine continued to be male-dominated

The result has been the development of physiotherapy theory which seeks to explain physiotherapy practice in terms of the medical model. This was the bargain struck in 1894 — we, the doctors, will allow and even encourage you, the physiotherapists, to practise — so long as you justify what you do in our (medical) terms. It has denied physiotherapy the chance to define its own knowledge base and has led to the moulding of physiotherapy practice to meet the needs of the medical profession. An examination of the medical model will demonstrate how close the links are between its underlying beliefs and physiotherapy. The claims that physiotherapists are working not to this model but to either the social model or to a holistic model need to be validated in terms of their acceptance of the beliefs that underpin these alternative models.

Theoretical Models

The medical model has been extremely successful — so successful in fact that it is often seen not as a model but as how things actually are.

> 'The dominance of the medical model has led society to believe it is the representation of reality not just one representation' (Mishler *et al*, 1981).

There are of course alternative ways of looking at the world and at aspects of health and illness. Some of the key models are shown in table 1. In physiotherapy, and health care literature generally, the same three medical, social and holistic models are most often quoted. They are examined in some depth in this paper to demonstrate possible alternative ways of explaining physiotherapy practice.

Table 1: Theoretical models

Biomedical	Economic
Social	Behavioural
Holistic	Materialistic
	Geographical
	Biopsychosocial

The (Bio)medical Model

The medical or biomedical model — the names appear to be used synonymously in the literature — is made up of a set of key assumptions about issues relating to the working of the human body and the disease process (Mishler *et al*, 1981; Eyles and Woods, 1983; Pratt, 1989). These key assumptions are shown in table 2.

Table 2: The (bio)medical model

Normal/abnormal	Sequential progress
Specific aetiology	Reductionism
Generic diseases	Dualism
Scientific neutrality	

Normal/abnormal

Fundamental to the medical model is the concept of normality, deviations from which are abnormal. This, like the other assumptions of this model, also underpins much of the explanation given by physiotherapists of their practice and shows how closely it is linked with this model. 'Normal' and 'abnormal' are words physiotherapists use constantly to describe gait, patterns of movement, range of movement, and functional ability. A fundamental concept in physiotherapy practice is the returning of a pattern of movement from the abnormal range to the normal. Much of physiotherapy is based on the belief that there are normal ranges of functional ability, normal ways of performing activities, normal patterns of movement and activity. Physiotherapy to a large extent deals with deviations from these normal limits and attempts to return the instigator of abnormal movements to within the framework of normal.

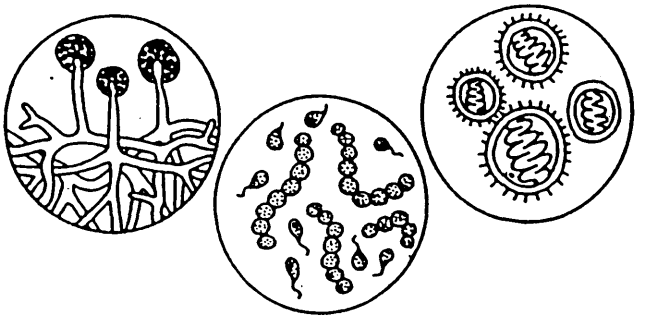
However, the validity of normal and abnormal as objective measures has been widely challenged by many writers. The key objection is that what is normal within one culture and at one time in history may not be normal within another framework (Ryle, 1961; Illich *et al*, 1977). Similarly, the literature on the emergence of the disability movement (Finkelstein, 1981; Davis, 1990) challenges the equating of normal with usual or average, and of abnormal with unusual or different. To define as abnormal puts what may be personally acceptable behaviour or functional patterns within the sphere of the medical model and physiotherapy picks it up within that framework — this is different, therefore it is abnormal, therefore it must be changed to normal, or as near to normal as possible.

To accept that normal and abnormal are culturally determined and are not objective measures means that the framework within which much of physiotherapy is practised falls away. If normal cannot be used as an external, objective standard against which to measure the effectiveness of physiotherapy intervention, the nature of which will be determined by a desire to attain that standard, then alternative paradigms have to be found which will both determine the nature and measure the effectiveness of what physiotherapists do.

Specific Aetiology

Specific aetiology is the belief that illnesses and diseases have specific causal agents. Its origins are in the isolation of micro-organisms which appeared to be the specific cause of particular groups of symptoms. The work done by Pasteur, Koch and others in the 19th century led to the development of the germ theory which has become integral to our understanding of infectious disease. So powerful and influential is the germ theory that the concept of a specific identifiable external agent as the cause of disease has spread from infectious disease to all aspects of ill health.

The search for the causal agent of each episode of ill health or cluster of symptoms has had an immense influence on our understanding of health and illness. There are alternative ways of looking at the causes of ill health, and economic, social, and geographical models have been developed to explore these (Eyles and Wood, 1983). However, the belief that the way forward in terms of medical knowledge and healing people is to identify a tangible organism — a germ, virus, gene, or chromosome — to match each known disease, has hardly been challenged.



Fungus, bacteria, virus — the germ theory reinforced the concept of illness caused by external agents

Generic Disease

Generic disease encompasses the idea that diseases are specific entities that exist outside cultural and historical limits (Parry, 1993) rather than being useful man-made labels to hang on groups of symptoms. Differences in disease descriptions or terminology between different cultures and periods of history are explained, by those who adhere to this theory, as differences in knowledge and understanding, rather than equally valid explanations of phenomena. The emergence of 'new' diseases is linked to new causal agents such as mutant viruses rather than being new explanations of symptoms which have always been present in the world population (Engel, 1977).

Adherence to this concept has been the main factor in influencing the development of medicine that treats the disease rather than the person. The belief in the existence of diseases as specific entities identifiable without the individual host or sufferer has led naturally to the existence of groups or professions which exist to fight or eliminate these entities. What is commonly called orthodox medicine differs from homoeopathy, for example, in just this respect. Homoeopathy is directed towards enabling individuals to heal themselves and the treatment provided will take account both of the patterns of symptoms present and of the individuals displaying those symptoms. The treatment of a particular set of symptoms will differ from person to person as the individual is being treated. Medicine on the other hand is directed towards eliminating diseases and treatment will be determined by the disease rather than by the nature of the individual hosting it. Homoeopathy in other words treats the individual, medicine treats the disease.

Scientific Neutrality

This concept is crucial to the hegemony of medicine. The claim is that medicine is based on science, which is politically, culturally and historically neutral. Scientific objectivity or neutrality is held to be paramount and is the justification for the domination of health practice, education, and research by medicine. It has been challenged by many writers and is beginning to lose the central position it once held in the advancement of knowledge about health and health care. It is used to justify the randomised controlled clinical trial as the

method of choice for research in health, and as such is being challenged by those professions outside medicine, including physiotherapy, that are developing alternative methodologies (Roberts, 1992). However, many of these alternative methodologies are still based on the idea that objectivity is at best achievable, and at least desirable. Some methodologies are being developed which accept bias and subjectivity as part of the research process, but these are in their infancy in health care research (Parry, 1991).

Sequential Progress

Sequential progress explains the acquisition of a body of knowledge in terms of a sequence of steps. Knowledge is acquired, a problem solved, and that knowledge is then in place as a foundation for the next piece of knowledge. Progress is seen as logically and objectively determined by the uncovering of pieces of knowledge which when placed together will lead to some ultimate truth. This does not explain the different levels of knowledge and understanding of different cultures, or the loss of knowledge by civilisations which were less advanced than their successors.

Dualism

The 17th-century philosopher Descartes was responsible for expounding the concept of the mind-body split (Ryle, 1949). The dominance of this idea in modern society and subsequently modern medicine is evident in the development of separate professions dealing with mind and body. Physiotherapy primarily deals with disorders or diseases of the body, using physical means. The profession's awareness that this is not the whole picture and that mind and body are inseparable is evident both in the claim to be able to affect the mind through the use of physical therapies (Ramage-Mourier, 1993), and in the interest in psychology as a discipline which influences physiotherapy practice (CSP, 1991). However, the profession has not challenged the essential separateness of body and mind, and works essentially within a framework which accepts this split as real rather than as a philosophical model.

René Descartes (1596 – 1650): 'Cogito ergo sum'

Reductionism

Having separated mind and body, by defining them as entities which occupy different spheres of existence, Descartes then developed reductionism as the method of choice for the advancement of knowledge. Cartesian philosophy views the physical body as a machine, subject to mechanical laws. An examination of the individual parts of this machine will lead, according to this theory, to greater knowledge of the workings of this machine, and therefore to a greater understanding of how human beings function as a whole.

That this is a fundamental part of physiotherapy is self-evident. Much physiotherapy education is based on learning about the workings of the human body in terms of its constituent physical parts which are held to behave according to mechanical and physical laws. Much physiotherapy practice is based on these concepts, which may or may not be valid. They are however fundamental to the medical model and adherence to them implies acceptance of the medical model, willingly or not.

The Social Model

This is an alternative way of describing the experience of being ill, and in particular of disability. It is beginning to be cited in physiotherapy literature (French, 1992; Johnson, 1993) and is worthy of detailed examination. The acceptance of it as a theory on which to base physiotherapy practice requires close consideration, since part of its message is that rehabilitation services collude in society's disabling of physically impaired people. The model builds on the concept of disability as being socially determined rather than belonging to an individual disabled person. So long as disability is centred in the individual, as it is in the medical model, then resources are directed towards solving the problem presented by that individual — including the development of rehabilitation professions. If disability is determined by society, then resources have to be redirected towards making society less disabling — by changing the physical and psychological fabric of society.

The origins of this model lie in the politics of the disability movement. Writers such as Finkelstein (1981, 1984a, b), Davis (1990) and McKnight (1981) have built on work done by Illich *et al* (1977) and have developed a polemic model to underpin the work of contemporary disability organisations in their campaign for civil rights. Part of this civil rights initiative develops the concept of disabling professions and includes therapists as part of the problem faced by disabled people, not as part of the solution. This is therefore not a comfortable model in its current form for therapists but one which should be examined closely as it develops, particularly by those who desire to claim it as a basis for practice. An anonymous contributor to the proceedings of a utilisation conference (WRF, 1979) wrote:

> 'Finkelstein makes it difficult for researchers, practitioners and administrators to pursue the typical models of rehabilitation with the innocence they have until now.'

Holism

The origins of holism lie in post-Boer War South Africa and Jan Smuts' search for patterns in the chaos that had been created in South Africa (Smuts, 1952). Smuts was looking for meanings, for a whole to be found in fragmented parts. The theory that he developed was based on the belief that certain wholes are greater than than the sum of their parts. This flies in the face of reductionism as Smuts claimed that to examine parts of anything is meaningless — meaning can only be found in the whole. Holism has become increasingly attractive as a model upon which physiotherapists, and others, can claim their practice is based. However, holism may be fashionable but the fact that it contradicts so much of what is fundamental to the medical model has led to a re-defining; the 1990 *Oxford English Dictionary* defines it as:

> 'The treating of the whole person including mental and social factors rather than just symptoms of a disease.'

This later definition happened in reaction to accusations that medicine was too reductionist (OWLS, 1992). Holism in its true sense is incompatible with the medical model, but is politically attractive to medicine, so it has had to be re-defined. What we have with this re-definition is what Engel (1977) describes as the biopsychosocial model. This involves dividing human beings into three distinct but inter-related entities — a biological being, a psychological being and a social being — examining all three and then adding them together to make a whole. This ignores Smuts' premise that we need to look at the whole first to make any sense at all of the parts, and that indeed it is only through belonging to a particular whole that a part acquires any meaning. The biopsychosocial model is not holism by another name; it is an aberration of holism which is attractive to physiotherapists as it does not threaten the concepts of the medical model. It is what Bevis (1978) calls summative dualism to distinguish it clearly from holism.

Discussion

No one can argue that physiotherapy has not regained important parts of its autonomy. Direct referrals and non-medical management are clear indications that, following nearly a century of basking in the patronage of the medical profession, physiotherapy has taken important steps along the road of self-determination. Indeed, Jones (1991) has argued that the recognition of physiotherapists as autonomous practitioners, along with management of the profession by physiotherapists rather than doctors, are the key elements which demonstrate that physiotherapy is no longer dominated by medicine. However, this does not acknowledge that practice is based on theory, and that theory develops out of practice. Without theory free from medical dominance, physiotherapy practice will still be medically controlled (Miles-Tapping, 1985; Parry, 1991). This paper has set out to demonstrate that only through a full understanding of the beliefs which underpin their practice will physiotherapists be free to choose whether or not to continue to be dominated by medicine.

A profession which is attempting to define its own knowledge base without an examination of the fundamental beliefs which underpin it is bound to be confused. This confusion has manifested itself in conflicts and tensions in practice, management, education and research. In all these areas physiotherapists claim to be working within one of the theoretical models. It has become fashionable to reject the medical model and to damn it for not being holistic. The claim is that physiotherapy is holistic and therefore it is inappropriate to use the medical model. However, if one discusses the concepts that underpin the medical model it is clear that many of them underpin, rightly or wrongly, physiotherapy practice, management, education and research. To reject the medical model and take on board another model is only sensible if the paradigm of that other model is compatible with the paradigm of physiotherapy as understood by an individual practitioner or by the profession as a whole. It is difficult to see direct links between physiotherapy and the social model which currently argues for the abolition of the profession, or physiotherapy and holism which demands an abandonment of precious reductionist practices.

Physiotherapy has, as we have seen, very successfully allied itself to medicine from the inception of its professional organisation to the present time. This has meant accepting medical dominance not only of our practice, but also of our theory. Physiotherapy is therefore very firmly embedded in the medical model. The desire for change is evident in the growing claims that physiotherapy practice is based on something other than the medical model. The profession currently is not comfortable with it. This may be because it is inherently incompatible with physiotherapy. It may be that the adoption of the medical model was no more than a pragmatic move which has served the profession well. However, what may have been a pragmatic move in 1894 has had profound and far-reaching effects in shaping the development not only of organisational aspects of physiotherapy, but also of the theoretical framework which determines its practice.

Alternatively, it may be that the medical model is so fundamental to physiotherapy practice that it was an inevitable step in 1894 — to ally physiotherapy to the profession which was not only dominant socially, but which was also responsible for developing the theoretical basis of its practice. It may be that to remove the concepts that underpin the medical model from physiotherapy will be to render physiotherapy powerless. The big dilemma facing the profession as it enters its second century as an organised force within mainstream health provision is that if the medical model is rejected as the basis for physiotherapy there may not be anything else to take its place. The profession has to be sure that the current dissatisfaction with the medical model is not just a passing phase but is crucial enough to warrant the development of an alternative theoretical basis for the practice of physiotherapy. This alternative theoretical basis has to be found within and developed from this very practice. Physiotherapy must stop looking to other disciplines' theoretical frameworks for an explanation of why it does what it does and begin the task of developing a physiotherapeutic model of the theory and practice of physiotherapy as demanded by Williams in the 1986 Founders' lecture (Williams, 1986).

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Article/Letter to the Guardian

Editor:

The Future is bright: The Future is a Rehabilitation Therapist

David Brindle's interesting article (Society: June 21) on the Audit Commission's study on the care of older people and fragmented, ineffective rehabilitation services is no shock to us as health care workers. Let the disorganised, muddled picture that the Audit Commission's study describes, be a thing of the past.

One of the causes of the problematic fragmented and ineffective rehabilitation service is the continuing existence of traditional professional demarcation boundaries. We write as health care professionals, aware particularly of the state of affairs with occupational and physiotherapists, who provide much of the core rehabilitation for all age groups at the acute, intermediate and community stages.

The Government has thrown down the gauntlet to health professionals to look more creatively and flexibly at their practice and the time is now right for action. The traditional assumptions about professional roles in the NHS are currently being challenged and occupational and physiotherapists need to consider their future carefully.

The shift of health care settings to a more primary care based focus and the growth in the aging population are driving the future of rehabilitation professionals like never before. However, the one factor that should alter the mindset of the health professional must be the increasingly heard voice of the consumer. Service users want more rehabilitation and of that there is little doubt. What they don't want is the confused and haphazard service many experience at the moment. The baffled user is confused by a service with many different professionals doing, as far as the user is concerned, very similar jobs but not delivering a high quality "seamless" service that they expect and deserve

Physiotherapists and occupational therapists share many core skills. Practice role confusion has been shown to be particularly acute between occupational therapists and physiotherapists and very often there is unnecessary duplication of key tasks. For instance, this role overlap commonly occurs in the rehabilitation of older people, cardiac rehabilitation, stress management and occupational health screening. Physiotherapists and occupational therapists may both be in the same team, asking the same questions, aiming for similar goals and as a result confusing the user and duplicating the workload. This does not make an efficient service.

In community settings where the approach tends to be more holistic the skill sharing tends to be even more marked. Traditional roles like, for example the provision of equipment for the home and assessment for wheelchairs are often shared successfully

resulting in a far more seamless and less confusing service for the user. Let us develop on this success.

The debate about skill sharing, role overlap and professional boundaries runs on internally in the OT and PT professional camps. However, serious talk about the future of the two professions is rarely addressed. Individuals are too busy holding onto their perceived areas of expertise and protecting their scarce resources rather than looking at responding to the needs of the service users.

Physiotherapy and occupational therapy students are currently educated at undergraduate level in Universities in the UK. Currently there are shared modules such as anatomy, physiology and behavioural sciences. The model of shared learning between occupational and physiotherapy courses is increasing. But is that enough? We propose one step further- that a full mapping exercise of skill sharing, commonalities and differences is undertaken with a view to ultimate merging of the two professions into one rehabilitation therapist who is truly responsive to the needs of the user in the changing NHS. This would provide one positive move towards the creation of a modern NHS, with the haphazard and fragmented service and the confused user a relic of the past.

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readers' letters

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Letters may be edited

A problem shared...

Your article on the audit commission's study on the care of older people and fragmented rehabilitation services (Home truths, June 21) is no shock to us healthcare workers.

One of the causes is the continued existence of traditional, professional demarcation boundaries. The baffled service user is confused by a service with many different professionals doing, as far as the user is concerned, very similar jobs but not delivering a high quality, seamless service that they expect and deserve.

Physiotherapy and occupational therapy students are currently educated at undergraduate level in universities, with shared modules such as anatomy, physiology and behavioural sciences. The model of shared learning is increasing. But is that enough? We propose one step further — that a full mapping exercise of skill sharing, commonalities and differences is undertaken with a view to ultimate merging of the two professions into one role of rehabilitation therapist who is truly responsive to the needs of the user in the changing NHS.

Pennie Roberts, principal lecturer, and Sue Smith, senior lecturer, in physiotherapy, Leeds Metropolitan University; Simon Balmer, consultant in public health medicine, Tees health authority

Foundation's "strategies for living" programme has worked for three years on discovering just what does really work for those experiencing mental health problems. While pharmacological approaches are important, our research reported that a range of other strategies — talking to people, accepting relationships, support groups, alternative therapies, economic independence — were highly significant in people's self-management.

Unfortunately, funding dictates that at present the weight of evidence is on the side of the pharmaceutical companies. Only a fraction of these total resources have been available to evaluate alternative non-drug-based therapies.

with the medication regime. I know of no study that has shown improved outcome in schizophrenia with CBT and simultaneously stopping the medicines. On the other hand, the increased rate of breakdown when patients stop their drugs prematurely is well documented.

It is not simply a case of either/or, but of working together that gets good results. In my own team, as in many others, nurses have been trained in these techniques and regularly use them in conjunction with encouraging patients to continue with their medicines.

Tom Burns, professor of community psychiatry, St George's hospital medical school, London

Jobs worth doing

People with a learning disability are denied jobs through fear, ignorance and a belief that they have nothing to offer the competitive market place. However, Mencap's employment service, Pathway, again and again successfully matches employers and employees in jobs across the employment spectrum (letters, June 28).

In reaching businesses, we would be naive to ignore the reality of productivity and profit. Yet the effective contribution made by employees with a learning disability has until now been largely ignored. It is important to write and talk about employment issues, but we must

laurie taylor

Time to join the real world

Nowadays, I routinely encounter former social s
ence colleagues who appear to have abandoned
normal intellectual discourse on public issues in
favour of an extended monologue about the diff
ties they are having meeting research deadlines.
can understand such anxieties. My friends know
too well that their failure to produce the requisit
number of articles in time will have serious fina
implications for their department and might als
mean their own demotion to a teaching only fu

But though the results of this pressure are ev
in the dramatic rise in the
ber of published research
cles, as well as in the appe
ance of more and more jo
to accommodate this incr
output, there are now que
being asked about the rel
of much of this research.

Academics have become "lost in language

Only two months ago,
Anthony Giddens argued
LSE lecture that universi
longer had the type of mo

Role Overlap and Professional Boundaries: Future Implications for Physiotherapy and Occupational Therapy in 'he NHS

orum

Key Words
Interprofessional relations, occupational therapy, physiotherapy, professional role.

by Susan Smith
Pennie Roberts
Simon Balmer

ummary Traditional assumptions about professional roles and tructure in the modernising National Health Service are being hallenged.

The changing nature of healthcare, the increase in the older opulation, and staffing implications are all key issues affecting the uture of occupational therapy and physiotherapy as future eparate professions. These complex changes are potentially hreatening for these professions as they currently exist.

will, therefore, be necessary to find solutions to these issues the healthcare labour force is to be responsive to meet the hallenges ahead in the changing NHS.

Role overlap, role confusion, fragmentation of therapy services, hared learning and a melding of the core skills and philosophies f occupational therapy and physiotherapy are the drivers for hange and modernisation discussed in this paper.

The paper offers the suggestion that occupational therapy and hysiotherapy undergraduate education programmes should be mbined. It also recommends that a creative, independent and mprehensive review of future workforce planning should be dertaken and states that the real way forward is towards the eation of highly skilled rehabilitation therapists who would be uly responsive to the needs of service users.

'th, S, Roberts, P and mer, S (2000). 'Role rlap and professional ndaries: Future lications for siotherapy and upational therapy in NHS', *Physiotherapy*, 8, 397-400.

Introduction and Background

Traditional assumptions about professional roles in the rapidly changing National Health Service (NHS) are being challenged. The British Prime Minister, Tony Blair, recently affirmed that modernisation is high on the political agenda.

The removal of professional boundaries is a main focus for the government's new NHS. Action Committees have been formed to modernise and change the NHS by evaluating current practice and skill mix, questioning the assumptions of yesterday and formulating policy for the future. The professions allied to medicine are facing major challenges in reshaping the NHS workforce. As Doyal and Cameron *et al* (2000) write: 'The problems have been well rehearsed but solutions seem as far away as ever.'

This paper aims to discuss factors which influence the provision of physiotherapy and occupational therapy service delivery, and consider the nature of these professions now and in the future. It proposes that ultimately the two professions should merge.

Changes in Healthcare Delivery

The shift of healthcare services into the primary care setting, increasing numbers of older people, the rise in chronic diseases and the philosophy of a more client-centred service are the drivers of changing physiotherapy and occupational therapy roles in this new millennium. As a result of these issues, there will be a greater demand for healthcare and an increasing need for therapists.

The move to form primary care groups and primary care trusts, that have the responsibility for commissioning secondary care and improving the health of the population, is becoming one of the lynchpins of the NHS. Two-thirds of hospital beds are occupied by elderly people (DoH, 2000a), the population itself is ageing and expectations of older people are changing. The need for continuing care and rehabilitation in both acute and primary care settings is increasing rapidly. New and more effective ways must be found to help these older people regain their health and independence.

Consumerism and increasing client-centred care will add impetus to changing therapists' roles. It is crucial that the fundamental principles of client-centred practice remain at the forefront of occupational therapy and physiotherapy. Therapists have a unique opportunity to facilitate client autonomy through the nature of their rehabilitation work and their functional approach to assessment and treatment. The goal of a seamless service between the acute and community sectors 'draws on the assumption that the client is not so much concerned with the issues of

multidisciplinary demarcation as receiving a service that is both efficient and effective' (Biggs, 1993).

A service with many different professionals doing, so far as the user is concerned, very similar jobs but not delivering a high quality service is not the service that users may expect or deserve (Audit Commission, 2000). As Potts (1996) stated, the challenge facing health professionals will be to justify why it is necessary to have 'so many separate professional groupings, each protective of their own boundaries, to assess, manage and implement care and rehabilitation'.

For physiotherapists, working in a client-centred more socially based model of healthcare is a radical departure from the treatment of patients in large acute hospitals dominated by a medical model of healthcare. The diverse scenarios of care in the community will challenge them and their perception of their own role and those of their fellow health workers (Richardson, 1999).

The staffing problems of the NHS continue to remain a major issue (Goldacre, 1998). The numbers of physiotherapists and occupational therapists, although increasing, will not be enough to meet the users' demands. There are many unfilled posts in both hospitals and community settings. For example, 20% of occupational therapy posts are currently vacant and there are similar shortages in physiotherapy. The National Health Service Executive has launched a three-year marketing strategy to attract new recruits and encourage professionals back to the NHS (*Frontline*, 2000). However, new approaches are needed to address recruitment issues.

The Professions of Occupational Therapy and Physiotherapy

Archetypal professions involve autonomous practice, an exclusive knowledge base, service to the public, self-regulation of standards and occupational control of rewards.

Both occupational therapy and physiotherapy have claimed professional status over many years. Both have established training courses at degree level, have licence to practise and public recognition.

By its very nature, the healthcare labour force is an interdependent one. Doyal and Cameron *et al* (2000) discuss how different occupational groups did not develop in isolation from one another but as part of a complex system capable of carrying out the many activities that make up the NHS. They write: 'Despite obvious reciprocity, the different elements of the NHS labour force are still planned and managed in isolation. This fragmentation has a major impact on the quality of patient care.'

Occupational therapists and physiotherapists share many core skills and the debate runs on about duplication of skills, professional boundaries and role overlap (Golledge, 1998; Brown and Greenwood, 1999) but serious talk about the real future of the two professions is rarely addressed.

However, some members of both professions have already sown the seeds of doubt in the minds of the traditionalists. Kay East, chair of the British Association of Occupational Therapists, has said: 'We need to be clear that our professional practice is unique or accept that we will be cast as generic workers' (East, 2000).

Physiotherapy literature also suggests that there may be a crisis of confidence in the profession (Bartlett, 1991) and the current drive for evidence-based practice is causing some therapists to doubt their credibility (Richardson, 1999).

Overlapping of roles has been shown to occur in ergonomics and occupational therapy (Hignett, 2000) and practice-role confusion is particularly acute between occupational therapists and physiotherapists (Conner Kerr *et al*, 1998). As Rothstein (1986) has said about physiotherapists: 'We, as a profession, may be doing more things, but in no way have we developed a true sense of who and what we are.'

Undergraduate Education

In the United Kingdom both occupational therapists and physiotherapists are currently educated at undergraduate level in universities. There are 29 university-based physiotherapy courses for undergraduate students and 27 for occupational therapy. There are many common areas in undergraduate training such as teaching of the basic sciences including anatomy, physiology and behavioural sciences. Both professional groups are taught skills such as problem solving, clinical reasoning and communication.

Six universities share modules between undergraduate occupational therapy, physiotherapy, and speech and language therapy. This model of shared education is increasing. Shared learning is popular among undergraduates and increases knowledge and understanding of other

healthcare professions. It also demonstrates the importance of multidisciplinary and interdisciplinary teamwork – vital in this time of increasing collaboration with other professionals (Parsell *et al*, 1998).

Is shared learning enough, however? We propose one step further – that these shared learning modules and other forms of interdisciplinary education ultimately result in a dual qualification with the hope that one day the professions will merge and a truly responsive rehabilitation therapist will evolve.

Physiotherapy and Occupational Therapy Roles

Occupational therapists, with their in-depth knowledge of mental health issues, are involved to a greater extent than physiotherapists in psychotherapy, small-group work and counselling skills for users of the mental health services. They have a greater input into behavioural programmes than physiotherapists and they have a considerable role in providing advice to users about strategies to cope functionally at home. They have considerable expertise in cognitive assessment techniques. Physiotherapists, however, have greater input in the treatment of individuals needing acute respiratory care, the provision of exercise-based activities and the diagnosis and treatment of musculoskeletal injuries. The use of electrotherapy is more prevalent and physiotherapists are taught specific soft tissue techniques and skills. There is considerable role overlap and unnecessary duplication of key tasks. For instance, role verlap occurs in the rehabilitation of lder people, cardiac rehabilitation and ccupational health screening.

Key areas of role overlap and skill sharing re more prevalent in holistic community ettings where traditional occupational erapy skills such as equipment provision, ome visits and wheelchair assessment nd provision may be shared with their hysiotherapy colleagues. Professional roles re more delineated in the acute setting ut there is still overlap in the provision f functional activities, neurological habilitation, the teaching of handling and nsfers and assessment of social needs.

The emphasis on evidence-based practice will continue and as a result, physiotherapists and occupational therapists will have to justify more robustly their place in the healthcare team.

Occupational therapists and physiotherapists are actively debating whether their support workers/assistants should be generic or profession-specific, but generally continue to look inwards when it comes to themselves. They are busy developing clinical specialists to protect the identity of their professions (COT, 2000) rather than view their own role overlap from the outside.

Conclusion

Occupational therapy and physiotherapy job roles are similar and there is current role confusion and overlap. Physiotherapists are becoming more aware of the 'care and support' philosophy rather than their traditional 'cure' philosophy (Richardson, 1999) and as a result the two professions, already close, may overlap further. Service users need adequate numbers of trained therapists to provide them with the effective, high quality rehabilitation service that they deserve. Doyal and Cameron *et al* (2000) discuss how some professions may not be sustainable in their current form and how new groupings may have to emerge to meet new needs. They specifically mention how occupational therapists face increasing difficulties in sustaining a specific role in an acute care setting.

Indeed, the Department of Health (2000b) has called for 'a more holistic approach to workforce planning than has been the case hitherto'. The professions of occupational and physiotherapy have core skills, unique skills and competencies that need to be mapped, analysed and explored in an independent comprehensive and wide-ranging review.

It may then be possible to recommend combined undergraduate education programmes leading to a dual qualification and ultimately have a truly combined profession.

These new rehabilitation therapists would be expertly skilled in all aspects of rehabilitation and truly responsive to the needs of service users in the changing NHS.

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Key Messages

- The removal of professional boundaries in the modern NHS will challenge the traditional professional structures of physiotherapy and occupational therapy.
- Changes in healthcare delivery and the burgeoning philosophy of client-centred care will add impetus to changing therapists' roles.
- The current division between occupational therapy and physiotherapy does not provide an ideal, client-centred, seamless service.
- Physiotherapy and occupational therapy may not be sustainable as separate professions.
- The way forward may be the creation of rehabilitation therapists

A golden blend?

There is potential for much closer co-operation between the occupational therapy and physiotherapy professions, to the point where the boundaries will be dismantled and a new discipline of rehabilitation therapy, combining the very best of both, will emerge, say Pennie Roberts and Susan Smith

The relationship between occupational therapy and physiotherapy has been a strong topic of discussion for many years.

Letters in the 1970s, discussions in the '80s, and conferences in the '90s all raised the issue of why there are two professions which both focus on rehabilitation and which both carry out largely similar functions.

To those outside the professions it is often perplexing, and to many inside it is no clearer.

However, there are reasons – historical and current – why the two professions developed and continue to exist separately.

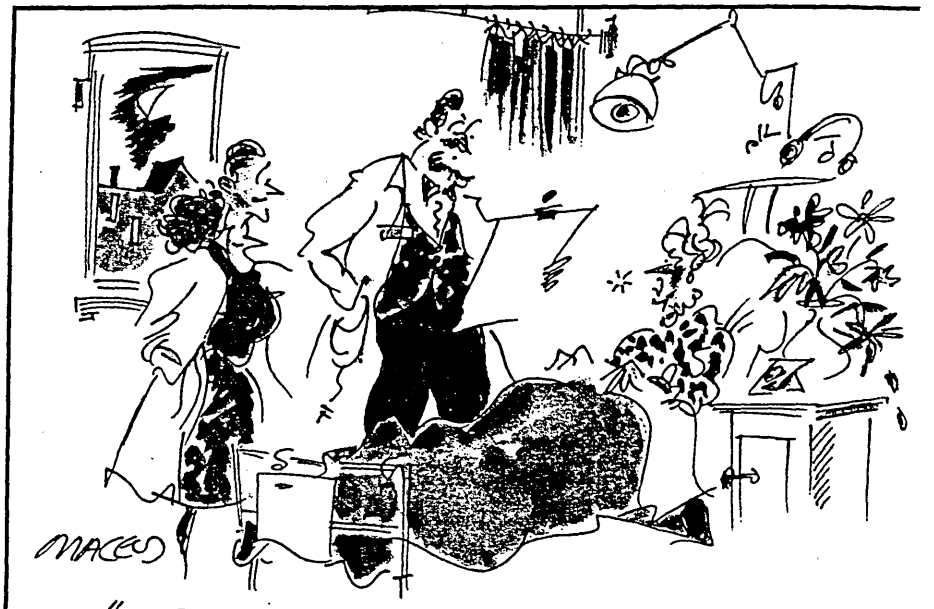
Each addresses issues of rehabilitation in its own way and each contributes a set of professional skills based around theoretical and practice models that are different and equally valuable.

The question this article attempts to address is whether the status quo is best either for the professions themselves or, even more importantly, for the users of the services we provide.

The two professions were formed, and grew up, in a world which was very different to the one in which we now practise and it is time to take a long hard look at whose interests are best served through defining ourselves by our differences, rather than by our similarities.

Clinically, there are many situations in which the two professions work across traditional boundaries, sharing skills and delivering a service determined by the needs of the service user.

Managerially, many therapists are now working within a broad therapy framework where departmental boundaries have been removed and where the focus is on what is common to therapists, rather than what divides them.



CARTOON: KEVIN MACEY

Educationally, shared learning is a reality for many therapy students, who graduate with a sound understanding of and respect for each other's discipline.

It seems, however, that attempts to engage in debate on acknowledging the growing closeness of the two professions quickly founder. Both professions appear to perceive their shared expertise as something to be hidden rather than something to be celebrated.

Rather than seeing each other as allies, there is a tendency to jump back behind professional barriers every time someone notices that actually, a great deal of what is going on in rehabilitation is not OT or PT specific but is determined by the needs of the user.

We are two professions, justifiably proud of our roots, our traditions and our core skills.

Reports from ill-advised sources calling for generic working and a forced merger to produce a "jack of all trades and master of none" halt any reasonable discussion on the reality of interdisciplinary working and on ways that this can be moved forward to deliver therapy services that are truly tailored to the needs of the individual user.

Rather than the generic therapist model – much derided and not a helpful contribution to the current debate – alternative models are needed to build on the professions' strengths and maximise the opportunities available to both in the current push for improved rehabilitation services.

The move to community working in primary care settings is a key driver for change. In primary care, and in client-based specialisms, role overlap and consequent skill-sharing is more evident than in hospital-based medical specialisms, and it is perhaps greatest in the area of rehabilitation – a term which has yet to be clearly defined, but which is very definitely in vogue, following recent government initiatives.

The therapy professions' response to initiatives on modernising the NHS and to the National Plan must include a rationale for the organisation and delivery of therapy services.

Certainly we can continue with the existing model of two professions working within multidisciplinary or interdisciplinary teams. There is nothing new there; it is a model that has been around for decades. But is it enough?

If we turn things around and look at what service users might want and expect from the therapists who work with them we can only second guess. But we must start examining what we do from the perspective of those whom we are there to serve.

If we take our therapist hats off and try to imagine what we might want, were we to be on the other side of the equation, we would want someone who was really, really good at what they were doing – not someone who could do everything, and none of it very well.

That professional would have knowledge and expertise which covered the whole area of our needs; someone who recognised their own limitations but didn't have to stop because the next bit was someone else's job; someone who could draw on a wide range of skills and tools to help us move forward; someone who could get on with what they were good at – rehabilitation.

What we are describing here is someone specialising in rehabilitation from a wider base than is currently available to either single profession, someone whose individual scope of practice has developed from a set of skills which has been drawn from the best we all have to offer.

This is about undoing the existing packages of OT and PT and allowing both sets of therapists to extend their practice into areas that have traditionally belonged to someone else.

In this new model there would still be therapists doing what we now recognise as occupational therapy or physiotherapy, and therapists specialising in existing areas in both professions.

However, there would, additionally, be therapists specialising in rehabilitation, drawing on a much more comprehensive set of practice models than is presently available to either profession.

Therapists from both disciplines have shown a remarkable ability to adapt to the demands of a changing society, a changing NHS and changes in higher education. But to date we have dodged the issue of how much more closely the two professions can move together.

We think there is potential for much closer co-operation, to the point where the boundaries will be dismantled and a new discipline of rehabilitation therapy, combining the very best of both professions, will emerge.

We think that we, the two professions, need to engage in this debate right now and grab the opportunities presented by the current reform agenda to ensure that users of our services get the very best we can provide.

Pennie Roberts is principal lecturer and head of physiotherapy at Leeds Metropolitan University, and Susan Smith is senior lecturer at Leeds Metropolitan University

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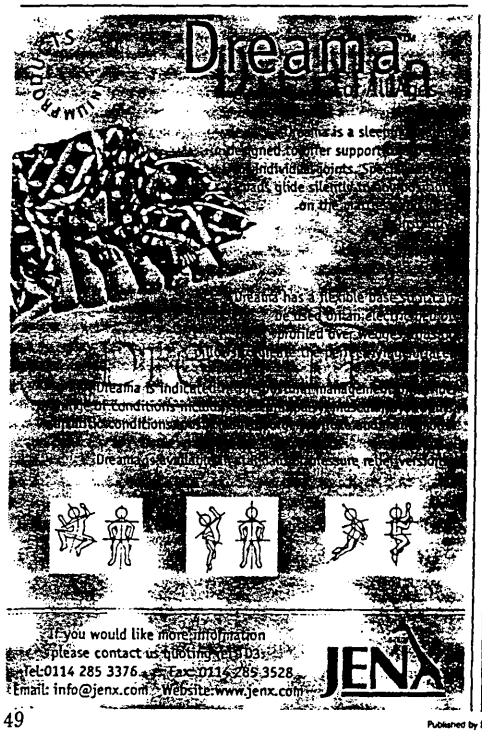

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