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Social power dynamics and partnership in stroke physiotherapy treatment interactions

by

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ABSTRACT

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SOCIAL POWER DYNAMICS AND PARTNERSHIP IN STROKE PHYSIOTHERAPY TREATMENT INTERACTIONS

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The Department of Health recommends that stroke patients should be encouraged to become 'expert patients' to work in 'partnership' with physiotherapists in the management of treatment. However, research suggests that this may be difficult to achieve because therapists and patients may have different agendas in treatment and this can hinder shared communication. Focus groups with stroke physiotherapists were conducted to explore these problems and these showed that social power factors in the institution were influencing the understandings and interactions of therapists and patients in some way. Six qualitative case studies of original research were conducted each comprising observation of a stroke physiotherapy treatment session and one follow-up interview each with the therapist and patient involved to examine how therapists and patients understood and used power in treatment interactions to achieve their own aims to clarify how this influenced partnership working. Within and cross-case thematic analysis using the 'Framework' method was carried out following a symbolic interactionist approach. Four 'case studies' from a previous related study were then subjected to secondary analysis using the same analytic framework. The results showed that the treatment sessions were structured by four interaction forms between the participants: 'Negotiation of leadership'; 'Treatment activities interactions'; 'Communication interactions'; 'Social interactions'. Patients used skill in social and communication interactions to negotiate 'good-patient' behaviour and information to delegate leadership to the therapists and to gain therapists' expert attention in pursuit of recovery. Patients' choice of a compliance role contradicts the 'expert patient' model but shows that co-operative working with therapists in the spirit of partnership is possible. However, lack of communication about strategic plans could hinder partnership working and this should be addressed.

CONTENTS

CHAPTER 1 INTRODUCTION

CHAPTER 2 LITERATURE REVIEW

CHAPTER 3 METHODOLOGY AND METHODS

CHAPTER 4 RESULTS OF STAGE ONE STUDY

CHAPTER 5 RESULTS PART ONE: SUMMARIES OF COMBINED CASE STUDIES AND INTERPRETATIVE DISCUSSION OF 'NEGOTIATION OF LEADERSHIP' AND 'TREATMENT ACTIVITIES INTERACTIONS' THEMES

LIST OF TABLES

LIST OF FIGURES

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Chapter 1 Introduction

1.1 Origins and focus of the PhD research project

The origins of this PhD research project stemmed from the Wiles, Ashburn, Payne and Murphy (2002) study which showed that physiotherapists and patients experienced difficulties in achieving shared communication about treatment and recovery in stroke physiotherapy. It was suggested that this was because therapists and patients had their own understandings of the purposes of treatment and what they wanted to achieve. The relevance of these findings for the practice of stroke physiotherapy was highlighted by the publication of government initiatives in 2003 promoting the development of 'expert patients' and 'partnership working' in the rehabilitation of chronic conditions such as stroke.

Whilst these concepts had some theoretical definition in the literature, there was very little empirical evidence of how they should be implemented in practice in clinical settings. Moreover, in the context of stroke physiotherapy treatment, it was not clear how the communication difficulties documented in the Wiles et al study might influence the development of the patient's 'expert' role and the therapeutic partnership relationship. It was evident that further research was required in this field. The present project was developed to use qualitative methods to examine the complex social dynamics of communication in the stroke physiotherapy treatment interaction in more detail. The intention of the work was to try to explain why problems in achieving shared understanding and communication between therapists and patients occurred and how this impacted upon the development of partnership working.

The project was developed in association with The Stroke Association who provided funding for a three-year PhD studentship at the School of Health Professions and Rehabilitation Sciences. I was appointed to the project as a full-time postgraduate student in October 2001 under the supervision of Dr Rose Wiles and Professor Ann Ashburn. Since October 2004 the study has been conducted on a part-time self-funded basis.

1.2 My approach to the research

My interest in undertaking this qualitative study derived from my mixed professional and academic background. As a registered nurse with experience in clinical research and a psychology graduate, I felt that this project would develop my academic research training and enable me to utilise my professional communication skills to good effect in rehabilitation clinical settings. In particular, the project enabled me to develop skills in different qualitative research methods such as focus groups and direct observation which may be useful in my future professional work. The subject of the research was also of great interest as I had little knowledge of stroke or physiotherapy. This work provided me with a most interesting perspective on the social power interactions existing in stroke physiotherapy treatment. However, these factors might also be used in the interpretation of the social power interactions between nurses and patients. This knowledge may be useful in developing future research and shared practice initiatives in my own profession.

1.3 Structure of the thesis

The PhD project comprised two studies which are called the 'stage one' and 'stage two' studies. The thesis presents a critical discussion of the key literature that is relevant to the two studies, including the clinical features of stroke, stroke physiotherapy, problems of communication in physiotherapy, theories of institutional social power and the ideals of 'the expert patient' and partnership. The methodologies and methods of the two studies are then presented. This is followed by one chapter presenting the results and discussion of the stage one study and three chapters presenting the results and interpretative discussion of the stage two case studies. The final chapter presents a general discussion of the research findings and theoretical models developed in the stage two study as well as a critical appraisal of the study methods and process and recommendations for future research.

Chapter 2 Literature review

2.1 Introduction

This chapter will present a critical discussion of the literature that is relevant to the phase one and phase two studies of the project. A brief overview discussion of the literature on the general features of stroke will be presented. Following this, the chapter will focus in more detail upon the literature concerned with the therapeutic management of stroke, in particular physiotherapy and will critically appraise the evidence of how treatment is managed and communicated in therapy practice, what is known about the problems of shared involvement in treatment and the recent ideologies of the patient expert and the therapeutic partnership.

2.2 The stroke event - an overview

2.2.1 Epidemiology of stroke

Stroke - or cerebrovascular accident - is the sudden disruption of the blood supply to a localised area of the brain (Rudd et al, 1999). It leads to damage or death of the surrounding cerebral tissue resulting in locally defined neurological impairments (Hildick-Smith, 2000). Stroke is described as a major killer in the western hemisphere (Hildick-Smith, 2000; National Statistics, 2001). In the most recent government stroke audit of November 2005 it is recorded that 110,000 stroke events are taking place annually in England alone and of these victims, up to 30% will die within the first month (Department of Health, 2005). Indeed, whilst stroke used to be considered the fourth most common cause of death in England, behind cancer, heart disease and respiratory disease (National Statistics, 2002), it is now described as: 'one of the top three causes of death in England' (Department of Health, 2005). Despite this evidence of the high mortality of stroke, the literature shows that many people survive stroke with serious disabilities which require support from families and professional services (National Statistics, 2001; Department of Health, 2005). The latest figures from the Department of Health audit (2005) estimate that at least 300,000 stroke patients are in these circumstances. From the data discussed here, it is evident that stroke is a significant health issue in the United Kingdom. This may become even more apparent upon examining the clinical features of stroke.

2.2.2 Clinical features of stroke

The physical impairment experienced after stroke may be variable in severity and recovery (Laidler, 2000). Most patients will experience a degree of hemiplegia - or sensory and functional deficit on one side of the body - the side and extent of which being determined by the severity and site of the stroke lesion in the cerebral cortex (Hildick-Smith, 2000). In a little more detail, hemiplegia results in sensory loss and paralysis of the muscles of the trunk and limbs on one side of the body (Edwards, 2002). The patient may also experience disruption of the control of balance of the body, which may render them vulnerable to falls if they are sitting, standing or carrying out any activity without adequate support or supervision (Laidler, 2000; Edwards, 2002). Impairment of spatial awareness through the visual field on the affected side may also affect the patient's sense of balance and hinder their ability to traverse objects in their environment safely (Hildick-Smith, 2000).

Further constraints may be met as the loss of limb control and sensory awareness prevent weight-bearing on the affected leg and function of the affected arm (Edwards, 2002; Laidler, 2000). Moreover, despite the sensory loss on the hemiplegic side, the patient may experience distressing pain in the affected shoulder, which lacking muscular support, is vulnerable to further damage if not provided with external support at all times by the patient or his or her helpers (Hildick-Smith, 2000). This may increase the patient's vulnerability and dependence on others if he or she is supporting the paralysed arm with the functional hand during activities. Communication deficits induced by the stroke may also present severe problems. Patients may be unable to comprehend instructions or may have difficulties with expression and this state is identified as 'dysphasia' (Hildick-Smith, 2000). Some may be unable to control the parts of the mouth and throat which produce clear speech resulting in 'dyspraxia', 'dysphonia' or 'dysarthria' or may lack speech altogether which is called 'aphasia' (Hildick-Smith, 2000). Patients may also suffer memory and concentration problems and impairment of their perceptual acuity (Laidler, 2000).

2.2.3 Recovery from stroke

The literature documents several factors which are commonly thought to be important in the process of recovery from stroke. These are the natural recovery of cerebral function through the body's complex ability to compensate by diverting function to neighbouring structures in the brain (Twining, 1988; Bach-y-Rita, 1991), medical treatment interventions (Bach-y-Rita, 1991; Hildick-Smith, 2000), the stimulation of activity and retraining of physical function through physical therapies (Bach-y-Rita, 1991; Davidson & Waters, 2000) and the patient's own motivation and physical endurance (Maclean et al, 2000; Bach-y-Rita, 1991). Two of these factors are of particular interest in the present study, namely the physical therapy treatment interventions in the rehabilitation of stroke and the role of the patient in the rehabilitation process.

These are of interest because they highlight important questions about the psychosocial aspects of stroke rehabilitation, in particular the effectiveness of the therapeutic interaction between physiotherapists and patients of which little appears to be known. Questions arise regarding how presumably complex physical therapy treatment interventions are managed and communicated with patients during rehabilitation. These issues will be discussed in more detail in a later section of this review. First however, it would be useful to gain a clearer understanding of the role of physiotherapy treatment as one of the key interventions in stroke rehabilitation.

2.3 Management of stroke

2.3.1 Physiotherapy treatment in stroke

One of the key treatment interventions in stroke rehabilitation is delivered by physiotherapists whose role is described as treating the physical impairments associated with stroke to enable the patient to achieve as independent a level of function in everyday activities as possible (Lennon & Hastings, 1996). Not all those who suffer a stroke require hospital treatment (Khaw, 1996), but generally, most patients will be assessed and given some form of treatment by a physiotherapist (Partridge et al, 1993; Sackley & Lincoln, 1996). Stroke physiotherapy treatment is typically divided into acute, rehabilitation and domiciliary services (Lennon & Hastings, 1996). The Stroke Association (undated) information booklet for stroke sufferers 'Physiotherapy and Strokes', informs us that patients may receive physiotherapy treatment in hospital or as an out-patient at hospital clinics, at Day Centres, the GP Health Centre or in their own homes. Other literature refers to rehabilitation for stroke taking place in dedicated hospital stroke units in comparison to that provided in general hospital medical or elderly care units (McGrath & Davis, 1992; van Gijn & Dennis, 1998; Elsworth et al, 1999; Kwakkel et al, 1999).

It can be seen that rehabilitation services for stroke are often diversely distributed in the NHS. This raises speculation of how such diverse treatment services are managed throughout the patient's rehabilitation and if there are problems in keeping the patient informed without encountering confusion and dissatisfaction. A more detailed examination of stroke physiotherapy treatment may help to shed light on what takes place during rehabilitation and how treatment is managed and communicated in the clinical setting.

Treatment for stroke is a skilled field in physiotherapy clinical practice (Ashburn et al, 1993). A range of treatment methods may be adopted by physiotherapists on the basis of several factors including training and on-going education, clinical experience, professional and prevailing local preferences and the patient's presenting problems and progress (Nilsson & Nordholm, 1992; Sackley & Lincoln, 1996; Lennon et al, 2001). From an uninformed lay perspective, there is probably little understanding of what takes place in stroke physiotherapy (Pound et al, 1994a; Payton et al, 1998). Even fellow health professionals in the rehabilitation setting - such as nurses - may perceive physiotherapy as being concerned with physical exercises and mobility, with little appreciation of the rationales and psychosocial aspects of treatment (Dalley & Sim, 2001). In fact, it appears that stroke physiotherapy is not a static field of practice, but one in which lively professional debate continues apace (e.g.: Sackley & Lincoln, 1996; Lettinga, 2002). The main debate within the profession appears to be about the efficacy of the different treatment methods existing in stroke physiotherapy and how therapists rationalise the treatment choices they make in practice (Ashburn et al, 1993; Sackley & Lincoln, 1996; van Vliet et al, 2001; Lettinga, 2002).

Considering the complex nature of the physical impairments in stroke and the uncertainty of their recovery, it is not surprising that physiotherapists appear to face a difficult task in clearly defining its treatment. However, more interesting in the context of the present study are the questions these debates raise, such as how do physiotherapists communicate treatment choices with patients if these details are difficult to predict and define in practice? Moreover, does this affect the way that patients understand and define their own role in the therapy process? It will be useful to outline briefly the main treatment models commonly used in stroke physiotherapy before taking a closer look at the 'psychosocial aspects' in physiotherapy treatment hinted at by Dalley & Sim (2001). This may provide more insight into the way that physiotherapists define their professional power role and how they communicate this to patients and how this influences the patient's role in their interaction.

2.3.2 Models of stroke physiotherapy from the therapist perspective

Sackley & Lincoln (1996) describe ten different physiotherapy treatment approaches used in one geographical region in England. However, as Sackley & Lincoln explain only a few of these are used with any regularity by physiotherapists. The papers reviewed suggest that the 'Bobath' or 'normal movement' approach is the most popular method used in the United Kingdom and that 'Functional', 'Brunnstrom', 'Rood' and 'motor-relearning' approaches, whilst referenced, may be less frequently practised in this country (Ashburn et al, 1993; Riddoch et al, 1995; Sackley & Lincoln, 1996; Lennon et al, 2001; van Vliet et al, 2001). It is not the purpose of this review to debate the rationales of the different treatment approaches however. More important in the present study context are the conclusions that have emerged from reviews of the different treatment paradigms. These conclude that there is little evidence of superior clinical efficacy in any of the treatments and that there is still on-going debate about the rationales for the clinical application of the different approaches (Ashburn et al, 1993; Kwakkel et al, 1999).

It appears that treatment may be decided by factors other than the evidence on treatment efficacy since this appears to be inconclusive. Sackley & Lincoln (1996) and Lennon et al (2001) found in their reviews of stroke physiotherapy practice that therapists will typically utilise more than one treatment method in rehabilitation and that treatment changes are likely to be based upon the patient's lack of positive improvement or their physical and mental state which may indicate that a type of treatment is inappropriate. Forster & Young (2002) assert that treatment choices may be controlled by 'trial and error strategies' based around the patient's response to treatment. As therapists are noted to utilise individualised resources of training, experience and professional preference in their treatment choices, there is a sense that these are decisions based on professional intuition rather than formally reasoned plans (Nilsson & Nordholm, 1992; Sackley & Lincoln, 1996; Lennon et al, 2001). Whilst Forster & Young (2002) suggest that more clarity and openness is needed within the profession regarding treatment choices, it is still not clear how this complex reasoning process influences the way that therapists and patients interact and communicate during treatment.

Roberts (1994) examined the literature on the models of physiotherapy practice and concluded that the emphasis was generally on the medical model. This suggests that physiotherapists are defining and treating patients by focusing upon the physical problems to the exclusion of the social aspects of the patients' stroke and their social interaction in treatment. The important speculation here is that the medical focus of therapy practice may lessen the significance of the social identity of the patient in the stroke and its treatment process. If this is so, might it also influence patients' understanding and active engagement with their treatment? Strachura (1994) suggests that this may be happening because medically orientated therapy approaches such as Bobath which focus on the minutiae of tone and movement patterns may be beyond the comprehension of patients. With little understanding of what is being carried out in treatment, it is perhaps not surprising that patients lack the ability to challenge therapists about treatment. However, the medical-orientated approach in treatment may also have created its own authority which encourages patient deference. Evidently, the working relations of therapists and patients may be influenced in some way by the manner in which therapy is delivered. These matters undoubtedly require further consideration. First however, it would be useful to discuss the evidence describing patients' understanding of the role of physiotherapy in their rehabilitation from stroke.

2.3.3 Patients' model of physiotherapy treatment

A growing body of research has sought to describe patients' views of rehabilitation and their expectations of recovery following treatment (Pound et al, 1994a; Pound et al, 1994b; Cant, 1997; Clark, 2000; Shapero et al, 2000; Wiles et al, 2002; Cott, 2004). Much of the literature has found that patients generally value physiotherapy treatment after stroke, particularly as they tend to believe that it is significantly responsible for their recovery (Pound et al, 1994a; Cant, 1997). Clark (2000) notes that very few patients express negative views of rehabilitation. However, Pound et al (1994a) records that one of the commonest grumbles amongst patients is the amount of physiotherapy treatment received because there is a general wish for more. This suggests that patients possess a clear view of what physiotherapy can do for them and attendance at therapy in some way increases their sense of control over the stroke. Perhaps, as Pound et al (1994a) and Bury (1997) suggest, from the patient's perspective, rehabilitation treatment provides comfort and a sense that their bodies are moving. Several studies show that patients do have plans of their own in treatment in as much as they want sufficient physiotherapy to achieve recovery of physical function to enable a return to pre-stroke activities and lifestyle (Bohannon et al, 1988; Pound et al, 1994b; Clark, 2000; Tyson, 1995).

It can be seen that patients can have their own views of stroke and its rehabilitation and their own motivations for attending physiotherapy. It is less evident however to what extent these wishes are discussed openly with the physiotherapist in treatment. The consequences of this lack of shared discussion about treatment have been found to be distressing for many patients. Thus, whilst some research has shown that some patients achieve a satisfactory level of recovery (Clark, 2000), others have experienced disappointment at the end of therapy with the discovery that they are permanently disabled and unable to live independently (Doolittle, 1992; Pound et al, 1994a; Clark, 2000). The reasons why patients can be persistently unaware of the potentially limited outcome of their rehabilitation need to be clarified. Hoffman (1974) and Wiles et al (2002), suggest that physiotherapists may experience problems in talking to patients about aspects of their recovery. This is an important observation which will be examined in more detail shortly. First however, it would be useful to understand the way in which therapeutic treatment is planned and managed in practice and how these decisions are usually communicated between therapists and patients.

2.3.4 Planning and management of treatment in physiotherapy

The Chartered Society of Physiotherapy recommendations for practice (CSP, 2000) state that physiotherapy treatment should be managed with the aid of a formal treatment plan. This is described as a detailed statement of goals to be worked upon in the rehabilitation of the patient's physical impairments, with indications of what should be done to achieve these goals within a prescribed time frame and how any achievements or other outcomes should be assessed (Bassett & Petrie, 1999; CSP, 2000). The recommendations in the CSP suggest that therapists should carry out an initial assessment of the patient's physical function in order to establish a baseline picture of the patient's physical impairments post-stroke (CSP, 2000). Details about the patient's social and personal circumstances should also to be sought, from the patient if possible, or the family members if the patient's condition prevents effective communication (Crabtree et al, 1991). The physiotherapist is advised to work together with the patient and their family, to identify the patient's problems after stroke and to formulate and implement a goal-plan of how these are to be treated in physiotherapy (Lennon & Hastings, 1996; Bassett & Petrie, 1999; CSP, 2000). As these sources stipulate, it is important for the physiotherapist to take into account the expressed concerns and preferences of the patient and their family during treatment. The initial physical assessment and treatment formulation would generally take place soon after the patient's admission to the ward or out-patient department and would be reviewed at regular intervals throughout the treatment period (CSP, 2000). In this way, the physiotherapist would evaluate the patient's progress towards the desired goals and could identify and implement any changes to the treatment on the basis of any problems or achievements observed (CSP, 2000).

Tennant et al (1997) and Wade (1999a), assert that rehabilitation health professionals tend to conceptualise stroke and its management within a classification system conceived by the World Health Organization (WHO). According to Tennant et al and Wade, this system provides a structure to define the patient's stroke in terms of how it affects their physical state, their ability to carry out tasks and activities and their social roles in everyday life. In association with a variety of other tools purporting to measure aspects of patients' physical and psychological progress, the WHO classification system is used by physiotherapists to structure goal-plans which help to control the uncertainty of progress in stroke rehabilitation (Cott & Finch, 1991; Haas, 1995; Tennant et al, 1997; Wade, 1999a).

The Chartered Society of Physiotherapy Core Standards (CSP, 2000) asserts that treatment should be monitored and evaluated by physiotherapists throughout the treatment period on the basis of patients' progress. However, most of the literature reviewed which discusses the management of treatment appears to focus only on key landmark events such as the initial assessment of the patient, goal-setting activities and measurement of outcomes (Cott & Finch, 1991; Schut & Stam, 1994; Wade, 1999a; 1999b; Bassett & Petrie, 1999; Baker et al, 2001). It is not clear from these sources how successful physiotherapists are in achieving the standards of treatment management recommended by the Chartered Society of Physiotherapy or how patients are involved in this activity.

Goal-setting is described as useful in helping patients to become involved in treatment (Baker et al, 2001). It is also indicated as a motivational tool in treatment providing the goals set are relevant to the plans of patients (Schut & Stam, 1994; Bassett & Petrie, 1999). However, other researchers have observed that goal-setting is often inadequately communicated with patients (Wade, 1999b) and may be more relevant to health professionals' plans in treatment than those of patients (Playford et al, 2000). In a focus group study with stroke patients and others requiring long-term rehabilitation, Cott (2004) found that whilst patients say they want participation in goal-setting they feel they lack the ability and resources to make this happen. Despite there being a good deal of discussion about the issue of goal-setting in rehabilitation in the literature, it is still unclear how physiotherapists use these management plans as they pursue their particular aims in treatment or how this is negotiated with patients.

2.4 Communication in stroke management

2.4.1 Communication of treatment between physiotherapists and patients

The Chartered Society of Physiotherapy Core Standards (CSP, 2000) assert that communication with patients about treatment should be truthful, well documented and be conducted within the scope of patients' comprehension. However, the guidelines do not explain how physiotherapists are expected to handle the difficult aspects of communicating with patients about uncertain recovery. They do acknowledge that communication with stroke patients is a challenging process for physiotherapists. The literature pertaining to the therapeutic relationship between patients and therapists describes the need for therapists to nurture an honest and trusting relationship with patients (Lloyd & Maas, 1991; Stenmar & Nordholm, 1994; Stachura, 1994; Jones et al, 1997). The quality of the therapeutic relationship is identified as having a significant impact on occupational and physical therapy treatment outcomes (Barnard, 2003). This appears to be due to the encouragement and support the therapist is able to communicate to the patient through the shared understanding developed in an effective working relationship (Lloyd & Maas, 1991; Barnard, 2003).

The literature suggests that communication or cognitive impairments may prevent patients from actively seeking or absorbing information that might support better understanding of rehabilitation treatment (Coulter et al, 1999). Patients may for example, find it very difficult to concentrate on what is being said and may not comprehend or remember the physiotherapists' instructions (Hildick-Smith, 2000). These difficulties may be further enhanced by a variety of age and stroke-related problems including hearing and mental acuity problems (Ley, 1988), constant tiredness (Astrom et al, 1992; Hanger et al, 1998), depression (Clarke et al, 1999) or the cumulative problems of a second stroke (Samuelsson et al, 1996; Mayo et al, 1999). These compound difficulties may also affect the way that patients and rehabilitation staff interact and communicate during treatment. Thomas & Parry (1996) observe that healthcare staff may overlook the concerns of patients who do not or cannot speak up for themselves. In these circumstances, it is possible that the patients' inability to express themselves may not only hinder access to useful information about their care and treatment, but may reduce the opportunities for negotiation and interaction with healthcare staff and others who could provide support.

It is likely that such problems are contributing to the difficulties that stroke patients and physiotherapists are experiencing in communicating effectively about treatment and recovery plans (Wiles et al, 2002). The Chartered Society of Physiotherapy Core Standards (CSP, 2000) assert that patients require clear communication from physiotherapists to enable them to contribute their own wants and concerns and to understand what is taking place in treatment. Indeed, the needs of patients for clearly communicated information about stroke and its recovery is supported by Haffsteinsdottir and Grypdonck (1997) in their review of the patient's experience of stroke and by Lui and Mackenzie (1999) in their study of the self-perceived needs of Chinese stroke patients. Whilst the evidence shows that effective provision of information for patients is recommended in physiotherapy treatment, it appears that shared communication between therapists and patients in stroke rehabilitation is difficult in practice (Hoffman, 1974; Wiles et al, 2002). The evidence will be examined next to assess what is known about the difficulties that create barriers to shared communication in the plans of treatment.

2.4.2 Problems of shared communication in physiotherapy treatment

Swain (1997) and Williams & Harrison (1999) claim that 'jargon' used by physiotherapists can create problems in communication with patients. It is also documented that therapists use tactile processes to assess patients' physical states and to guide their movements during treatment (MacWhannell, 1992; Adams, 1994; Swain, 1997). Such tactile processes may be seen as particularly specialised modes of non-verbal communication. All of the studies mentioned above view this interesting form of therapeutic communication from the perspective of the therapist. It is not clear therefore, what patients understand of this tactile process or if they are aware of its significance in monitoring their activity and progress in treatment. Evidently, the way in which the technical and non-verbal therapeutic processes in physiotherapy are acknowledged and shared with patients during treatment needs elucidation.

The literature shows that many stroke patients have their own views and expectations of stroke, treatment and recovery and typically expect their own prognosis for recovery to be good (e.g.: Wellwood et al, 1994; Pound et al, 1994a; Cant, 1997; Doolittle, 1992). It is also known that patients often persist with these views throughout treatment sometimes even after formal rehabilitation is over (Wellwood et al, 1994; Wiles et al, 1998). As Wiles et al (2002) observed patients appear to continue to maintain their own expectations of recovery despite being given information by physiotherapists during treatment.

Perhaps this persistent belief of patients is due to the fact that physiotherapists experience difficulties in sharing the complex details of treatment with them (e.g.: Stachura, 1994). Practitioners appear to be generally aware during rehabilitation that many patients will not achieve full recovery and will suffer residual functional disability (Astrom et al, 1992; McGrath & Davis, 1992). However, as Hoffman (1974) and Wiles et al (2002) suggest, recovery and progress in treatment are often difficult topics for physiotherapists to discuss openly with patients. Hoffman (1974) and Wiles et al (2002) suggest that therapy staff are fearful of discussing lack of recovery with patients in case this influences their motivation and 'hope' in treatment. Wiles et al (2002) also suggest that physiotherapists are being reticent about discussing recovery with patients in order to prevent idealistic expectations of good recovery being fostered. This suggests that therapists are enacting information guarding strategies to control patients' attitudes and compliance in treatment. From the literature discussed, it appears that patients and therapists have different understandings in treatment that encourage them to have different agendas in terms of what is important to them to achieve in their different patient or therapist roles.

2.5 Summary

The literature reviewed so far highlights the complex nature of stroke and its rehabilitation. It shows how the treatment and recovery processes are often uncertain and difficult for therapists to share with patients in practice. There is evidence that therapists and patients harbour their own agendas in treatment and that their interactions with each other are influenced by the individual understandings of how these agendas should be achieved in their different roles in treatment. These individual factors may be hindering shared communication between therapists and patients about treatment and might influence the degree of partnership working that can develop. The evidence seems to suggest that power dynamics exist between therapists and patients in their interactions in stroke physiotherapy treatment. It also suggests that therapists and patients use different strategic plans to try to influence each other during the course of treatment to ensure that their own goals are met. However, there is still much uncertainty about the way that such social power activities are manifest and used in physiotherapy treatment. A closer examination of the literature on social power in the modern institution of healthcare and more specifically in the physiotherapy treatment interaction is essential to understand this complex dynamic and its implications for partnership working between therapists and patients.

2.6 Introduction to the concept of institutional social power

2.6.1 Perspectives of social power in the literature

Power is a broad concept which might loosely be defined as the potential for action and the force which initiates and sustains action (Coleman, 2000). In much of the human sciences literature power has been described as a relational concept denoting the social element in its origins and actions (Deutsch, 2000; Coleman, 2000; Foucault, 1988). The focus in this review will be upon the concept of power in society and the significance of social interaction on its existence and activity. Perhaps a good starting point would be to review the way that power in Western society was formalised from about the 16th century onwards, with the creation of powerful institutions of social control which still exert influence over society and healthcare today. Some of the most influential sources in the literature upon the subject of power in society are the writings of the late French philosopher Michel Foucault. Foucault's work provides a useful foundation from which the subject of power in the social world and in the institution of healthcare can be understood and developed.

According to Foucault (1982) the formal structures of power in Western society were established in the 16th Century on the basis of a series of official strategies. The purpose of these strategies was to identify and separate society's problems of madness, criminality and disease from the normal population in order to establish control (Foucault, 1982). These policies resulted in the establishment of 'The State' which was essentially a league of powerful bodies, including the 'economic, legal, spiritual and medical' professions which banded together to form a sort of government of experts (Rose & Miller, 1992). According to Rose & Miller, this organisation of powerful experts took up the official rule of society in order to guide it towards an ideal of social virtue and normality. A web of power was established by 'The State', creating social institutions which were intended to govern and control society (Foucault, 1982). As Foucault explains, these institutions were the 'family', 'marriage', 'prisons' and 'asylums'. Two of these institutions, the 'prisons' and 'asylums' were intended to house and manage people whose behaviour or circumstances were considered unusual and in need of controlled intervention (Foucault, 1982; Stacey, 1988).

According to Foucault (1982) and Giddens (1993), the powerful activities of these early State controlled institutions shaped the evolution of medical knowledge and medical practice to create the position of the institution of healthcare in society today. Similarities can be seen between Foucault's definitions of the purposes and powers of the early institutions of prison and asylum and the modern institution of the hospital. In the modern context, whilst admission of the patient into hospital might be said to enable treatment of physical and mental problems for the patient's own sake, the good of society also seems to be a consideration as individuals with different states of health still seem to make people uncomfortable.

2.6.2 Discussion of the rationales and evidence for institutional power

Foucault (1982) describes his view of 'The State's' institutional power as a 'pastoral' power. However, Rose & Miller (1992) define 'The State's' power as more 'political'. The historical descriptions of both models given in the previous section suggest that 'The State' was a patriarchal form of authority based upon the dominance of men in society. This agrees with Giddens' (1993) view that the wealth in most societies has been traditionally owned by men. It is interesting to note how the patriarchal model has persisted in healthcare, particularly within the hospital setting (Stacey, 1988). However, it is still not clear upon what basis the patriarchy of medicine has maintained its position in society and over the management of patients. In order to answer this question, it is necessary to look to the ethics literature.

Sim (1997) discusses one principle of medical ethics called 'beneficent paternalism' which seems to underpin most institutional healthcare despite more recent moves towards partnership working with patients. In this principle, decisions are taken for treatment against patients' wishes or without their consent being obtained (Sim, 1997). As Sim elaborates, this action is taken for patients' best interests if it is judged by doctors or other healthcare professionals that they are incapable of making these decisions independently. It is not difficult to imagine how frightened, shocked and vulnerable individuals in healthcare institutions would be open to the vision of powerful and beneficent healers with ability to help them in their need. It is possible therefore, that doctors, and other health professionals rely on the principle of beneficence as the justification for the exercise of their professional authority. Foucault describes three other strategies: clinical classification, surveillance and confinement which could be more directly implicated in creating the power of 'the professional' over 'the patient' in the institution of healthcare (Foucault, 1973; Foucault, 1982). It might be said that in isolating these key strategies of institutional power, Foucault made his most important contribution to our understanding of the institution of healthcare and its practice. Let us now examine the evidence of Foucault's theories of social power in the literature in more detail.

2.6.3 Foucault's seminal models of institutional power

According to Foucault, the power of the state is visited on inmates of institutions by exposure to intense objective and subjective scrutiny (Dreyfus & Rawlings, 1983, cited in Lukes, 1986). This is achieved in the first instance by the enclosure and confinement of 'problem' individuals in the physical manifestation of 'The State's' power, the asylums and prisons (Rose & Miller, 1992). Confinement in the healthcare context today could be defined as the internment in a building for the purposes of diagnosis, treatment and rehabilitation (Rose & Miller, 1992). It might be suggested that these intensive confinements for treatment could create feelings of fear, isolation, and pain. In fact, this may not be so far removed from what patients in the early institutions experienced.

One of the most interesting and graphic accounts of the use of confinement in healthcare in past ages was penned by the 17th century diarist Samuel Pepys which we can read courtesy of one of his most recent biographers Claire Tomalin (2003). As Tomalin reports Pepys underwent preparation for an extremely dangerous and painful operation to remove a stone from his bladder. This involved his being tied with ropes to the operating table and being sat upon by several large men to prevent him from moving and disturbing the surgeon during the procedure (Tomalin, 2003). This is obviously an extreme and brutal example of the necessities of control of patients undergoing surgery without anaesthetic in the 17th century. However, strategies which seem to illustrate institutional power such as enforced bed rest, immobilisation of the body using traction apparatus and the use of cot sides to restrict the movements of elderly confused patients are noted as being used in hospitals in the last 20 years (O'Brien & Draycott, 1984; Wood, 1984; Thelan et al, 1994).

As Rose and Miller (1992) and Foucault (1982) discuss, institutions can create and maintain a culture of power through practices of official observation and judgement by which individuals are classified as either 'mad or bad'. In these practices can be discerned the processes of diagnosis which may be more familiar as the physical examination and questioning by which doctors and physiotherapists identify problems and decide upon treatment. This leads to what is perhaps the most widely referenced strategy of Foucault – the process of surveillance, or 'the medical gaze' (Foucault, 1973; Foucault, 1982). In this strategy, institutions develop formal processes of physical, cognitive and personal examination and observation through which they are able to create specialised models of the patient as a series of clinical signs and symptoms (Foucault, 1973). The relevance of these issues in the modern day healthcare institution is shown by the active debate of their contemporary implications for patients and healthcare professionals in recent theoretical and empirical papers. These will be discussed next.

2.7 Evidence of power strategies in contemporary healthcare

2.7.1 Surveillance strategies

McIntosh (2002) discusses the iniquities underlying the processes of clinical examination conducted on elderly or disabled patients and suggests some interesting points that may be useful to explore with reference to the practice of stroke physiotherapy. McIntosh suggests that examination is a more powerful form of surveillance than that of routine observation because it gathers data on the patient to create a facsimile of them in medical jargon. In this sense, the patient becomes no more than 'a source of pathological data' (McIntosh, 2002). One of the most interesting points that McIntosh develops in this discussion is the question of whether it is the patient or the professional who can claim ownership over these data to use for their own ends. McIntosh speculates that patients might not have the ability to understand or use such information. The Chartered Society of Physiotherapy (CSP 2000) records that therapists are required to collect and use such information in the clinical assessments of treatment. In this respect, as Cott (2004) suggests, the collection and management of information might represent an important source of power for healthcare practitioners in their professional role.

The power of clinical surveillance is further discussed in the context of a hospital intensive care unit in an interesting paper by Amanda Henderson, a nurse in Australia (1994). Henderson expresses concerns that patient/nurse interaction in the intensive care unit is often impersonal and this seems to be encouraged by the way that patients are perceived by staff as sets of clinical data which have to be monitored, recorded and reported on 24 hours a day. These findings seem to suggest that the roles of health professionals, particularly those involved in carrying out highly technical processes where detail and accuracy are paramount may be controlled by the necessity of their professional and institutional responsibilities. As Palvianen et al (2003) found in a questionnaire study of nurses work in acute and long-term care, the responsibilities of professionals can lead to the necessity to control patients' activities and behaviour on the justification of 'service efficiency, safety and economy'. These studies illustrate the complex nature of the professional responsibilities of healthcare practitioners and the potential role conflicts that may be encountered (Sim (1997)

2.7.2 Classification of the individual as 'the patient'

Foucault (1973) suggests that the processes of physical confinement, intense physical and mental scrutiny and diagnosis within a disease or illness framework objectify and recreate the individual as a medical condition and 'a patient'. This redefining of the identity of the individual may be seen as an extremely powerful social strategy. It might influence the way society and individuals come to understand and experience the institution of healthcare and how the identity and power of the expert healthcare professional is created. An early study which dealt with the concept of patient-hood was that of Tagliacozzo & Mauksch (1972), which examined the perceptions of hospital patients regarding their position and role in the institution. The findings of this study show that patients in the hospital setting expect to be subjected to examinations and to be told what to do by the staff, particularly doctors and nurses. These conclusions suggest that patients act in response to social norms associated with the institutional setting of the hospital and this effectively defines the patient role.

Coleman (2000) identifies this social conditioning as a form of 'primary power' which is predicated on social meanings of particular 'domains'. These meanings include expectations of what happens to people within the domains and what models of behaviour are in force. This theory reflects the findings of Tagliacozzo and Mauksch's study (1972) and Waterworth and Luker's work (1990) which showed that patients expect to behave with deference towards hospital staff and to be compliant with their clinical orders. Both studies suggest that the belief systems of patients are based upon fear of rejection by doctors and nurses whom patients perceive as central to the success of their treatment and rehabilitation. However, it is also possible that patients are using strategies of social manipulation to influence the behaviour of health professionals during treatment in the hope that this might elicit greater attention and better care. Is there any evidence which can confirm the rationales for patient's social strategies in their interactions with professionals in hospital settings?

One study which develops a clearer insight into the experience of losing and regaining degrees of power in healthcare from the patient's perspective is by Tang & Anderson (1999). In this study, Tang & Anderson interviewed Chinese and English-speaking Canadian women regarding their long-term diabetes treatment. The findings of this study suggest that despite language barriers and poor information which remove patients' power over their condition, some patients are able to reclaim a sense of control by deciding they can 'resist patient-hood' and do things their own way. Further evidence of patients' strategic use of social interactions in treatment situations is found in work by Ainsworth-Vaughn (1998). In this study, Ainsworth-Vaughn used discourse analysis to describe the interactions taking place between physicians and patients in private medical consultations. In one case, the physician seemed take the lead forcefully in most of the decisions of treatment whilst the female patient communicated in a softer, less forceful and more respectful manner. In explaining these findings, Ainsworth-Vaughn suggests that whilst the patient's soft approach might have appeared to put her in a weak position in the negotiation of treatment, this was countered by the patient with quiet persistence about what she thought was right and this eventually got her the treatment she wanted. The patient's actions in Ainsworth-Vaughn's data do not seem passive but rather seem to illustrate the negotiation of social respect with the professional to gain treatment.

These are thought provoking studies as they actively question the model of the institutionalised patient as a disempowered individual who is humbly accepting of the expert ministrations of healthcare staff and has no skill to enact their own plans. They also highlight some key questions of the way that the power to act and make decisions over treatment is distributed in the healthcare interaction, how and why health professionals and patients use power to achieve what they want in treatment and why this is harder for patients to do (Ainsworth-Vaughn, 1998).

2.7.3 Physical confinement

The power arising from the physical confinement of patients stems from the process of hospitalisation which removes individuals from the mainstream of society and incarcerates them into the institutional domain for treatment (Rose & Miller, 1992). From this point onwards, with the patient under their care and responsibility, it appears that healthcare professionals adopt a different model of social interaction from that in force in everyday society as they infringe the patient's social space, touch them and control their activities in the process of conducting the clinical activities of treatment (O'Brien & Draycott, 1984; Wood, 1984; Thelan et al, 1994; Talvitie, 1996; Mott et al, 2005). Some of these physical control measures are evidently used for therapeutic or palliative purposes for example the use of traction to immobilise a damaged limb or the tactile guidance of a patient's limb in physiotherapy (Talvitie, 1996). However, others seemed to have more coercive purposes, thus the use of physical restraints or sedatives to control agitated patients (Mott et al, 2005). Whilst it is evident from the literature that some control strategies can be justified as therapeutic or palliative treatments, all physical and chemical tools which impair patients' movement whether to promote therapeutic improvement or to prevent harm must be coercive as they are effectively curtailing patients' rights to move freely.

As Mott et al (2005) discuss, strategies of restraint used with patients can have negative as well as positive implications for patients. Whilst patients may be prevented from harm by a fall from bed, they can suffer from severe physical and psychological deterioration as a result of being confined. This in turn can affect their progress in rehabilitation and their relationship with the nursing staff as they become dependent (Mott et al, 2005). In an attempt to address such problems, Cheung and Yam (2005) suggest that healthcare professionals should always obtain patients' explicit consent to use confinement techniques in care or treatment. However, in the case of elderly confused patients it is possible that obtaining informed consent might be difficult to achieve.

The use of confining restraints with patients seems to be fraught with many ethical conflicts regarding the rights of the patient and the beneficent purposes of healthcare professionals who use confinement strategies to promote patient wellbeing as the theoretical writings of Sim (1997) suggest. Cheung and Yam (2005) propose that the use of such power by healthcare professionals contradicts the principles of patient autonomy. What are the implications then for healthcare professionals who are expected to promote partnerships with patients whilst continuing to maintain a duty of care towards patients' wellbeing? Perhaps the answer may be found in a closer study of the complex social dynamics of treatment interactions in physiotherapy.

2.7.4 Power in physiotherapy treatment interactions

It is notable that much of the available empirical literature discussed with reference to power in healthcare pertains to the medical and nursing professions. This is an interesting observation as it suggests that very little work has been done in examining the power dynamics existing in physiotherapy treatment. This review of the literature has highlighted several examples of the way that power is used in healthcare provision which might be used in physiotherapy practice. Of particular interest in the context of physiotherapy are the Foucauldian power strategies of surveillance, confinement and clinical classification (Foucault, 1982). Some groundwork has been done by physiotherapists Williams & Harrison (1999) in a review of the physiotherapy literature. This review and other sources suggest that a significant part of physiotherapy treatment is comprised of complex techniques involving tactile physical examination, passive movement and guidance of body parts, much of it carried out without explicit verbal explanation to the patient (MacWhannell, 1992; Adams, 1994; Swain, 1997; Williams & Harrison, 1999). As McIntosh (2002) hints, it is possible that elderly patients with age or stroke related cognitive impairments might be unable to understand such techniques or their clinical significance in treatment.

Whilst Williams and Harrison (1999) refer to Foucault's philosophy of power as a relational concept in action, they do not develop his theories of clinical surveillance with reference to the complex tactile examination and monitoring techniques that exist in physiotherapy practice. Moreover, their discussion of the use of space in the physiotherapy treatment interaction could perhaps have been developed further with speculations of how this might be negotiated by patients or therapists using non-verbal communication (Hargie & Dickson, 2004). However, an interesting interview study was conducted which looked at the use and understandings of power in orthopaedic out-patient physiotherapy treatment interactions (Harrison & Williams, 2000). The results of this study suggest that therapists and patients recognise that therapists have power as the professional but patients have no understanding of their own power at all.

Parry (2001; 2004), used an observational conversation analysis approach to examine stroke physiotherapy communication during treatment activities and goal-setting. The conclusions of this research show that therapists and patients 'orientate' themselves in their treatment activities interactions in relation to their different abilities, the therapists taking the lead in the activities and patients a less participative role. Parry's findings suggest that patients and therapists may be negotiating their respective roles of power in some way during the treatment activities. However, the study does not explain the social rationales of this process or how the participants' perceptions and use of 'therapist' and 'patient' power influence the social orientations that emerge. Both Parry (2001) and Harrison & Williams (2000) seem to agree that the power interactions between patients and physiotherapists during treatment are complex and may be influenced by context and interpersonal social factors. However, the dynamics of these social issues and their meanings for the power of therapists and patients in their goal-directed interactions still appear to be unclear and in need of further elucidation.

2.8 Considering the strategic use of power

The literature discussed so far suggests that whilst the power of the present day institution retains the air of authoritarian medical dominance which it inherited from its historical forebears, its dynamics have become more complex (Foucault, 1982; Parsons, 1986). According to Lukes (1986), individuals understand that in order to achieve their own goals, they must promote them with appropriate action to ensure their success. This is supported by Foucault and others in the philosophical and psychological literature who suggest that power in society is a concept which emerges and is directed through the goal-driven social relations of individuals (Foucault, 1982; Coleman & Voronov, (2003); Coleman, 2000; Deutsch, 2000). Foucault (1982) also asserts that social interactions are 'reciprocal' and 'provocative'. This suggests that goal-directed strategic interactions are negotiations of power wherein participants gain their own power by supporting the authority of others. In reviewing the early 1920's work of Follett, Coleman (2000) suggests that social interaction can lead to a state of parity where participants negotiate their wishes to reach agreement for co-operative working towards achievement of the goals of both parties. This scenario is very suggestive of a model of partnership called 'concordance'. The merits of this and other models of patient involvement in healthcare will be discussed more closely now to determine what is known about this broad concept and its relevance to the advance towards consumerism in healthcare.

2.9 The ideology of therapeutic partnerships in chronic disease management

The Chartered Society of Physiotherapy (CSP, 2000) suggest that 'partnerships' should be developed between physiotherapists and patients to support the patient's involvement in the plans of his or her treatment. The CSP however, do not describe the nature of this particular working relationship. Nor do they offer guidelines as to how therapists should achieve or maintain it successfully in the clinical setting. Quill (1983), Law et al (1995) and Charles et al, (1999) speculate about some of the central tenets of partnerships in the healthcare context including negotiation of the goals and plans of treatment and negotiation of the roles and responsibilities that therapists and patients expect of each other and accept for themselves.

One of the rationales offered in support of more shared working relationships between healthcare professionals and patients in the treatment of chronic conditions is that patients should be enabled to better understand and cope with the lifelong nature of their conditions, in order to improve the quality of their lives (Department of Health, 2001a). There appears to be some support for this rationale in a study concerning patients with chronic orthopaedic conditions such as osteoarthritis (Johnston et al, 1992). Johnston et al found that patients experience greater 'perceived control' when they are enabled to be more involved with rehabilitation treatment via the provision of key information prior to their clinic appointments (Johnston et al, 1992). However, Coulter (1997) contradicts this optimism with the observation that evidence of shared partnership working in the management of chronic conditions is rare in reality.

Coulter's interesting paper reviews the pros and cons of various forms of partnership relationships in the literature and concludes that there are several factors such as patient age, education and social class which may hinder the ability of patients to participate in shared treatment decisions with practitioners. This suggests that the practicalities of partnership working are contradictory since they hardly seem to be inclusive for patient groups with fewer personal resources. Coulter also speculates that patients may not be interested in taking on a shared decision-making role in their treatment.

Other sources in the literature appear to support this critical view of partnerships in healthcare with particular reference to stroke patients (Crabtree et al, 1991; Coulter, 1997; Jones et al, 1997; Jones & Partridge, 2000; Beutow, 1998; Williams & Harrison, 1999). These sources suggest that the development of partnership working between older stroke patients and healthcare professionals could be more difficult than the official government publications speculate because of the age and stroke-related problems that this patient group often experience. Such problems might include difficulties in cognitive and communication functions which may hinder shared negotiation in the partnership process during treatment. Of course many patients with chronic health conditions other than stroke may not experience such extreme difficulties in communicating effectively with healthcare professionals. In these treatment interactions it is possible that partnership working may be easier. However, the National Statistics literature (2001) shows that a large number of people are now surviving stroke with chronic disabilities. Clearly the problems that this patient group experience should have a higher profile in the government's scheme for partnerships in long-term healthcare.

It is acknowledged from this review of the literature that not a great deal is known about how the dynamics of social power between stroke patients and their healthcare professionals interact. Nor is it known how these interactions impact upon the development of partnership relations in practice. However, before establishing plans for research in this interesting area, it would be useful to examine the ideological definition of 'partnership' more closely.

Law et al, (1995) suggest that one of the central aspects of successful partnerships in healthcare settings is that each partner has to accept a degree of responsibility. However, it is accepted that the patient's level of responsibility would not equal that of the health professional because as Quill (1983) points out, both parties have different areas of expertise and knowledge. As Quill (1983) and Charles et al (1999) recognise in their discussions of the doctor/patient relationship, there has to be a level of active negotiation between the 'partners' regarding all aspects of treatment. These aspects include individual preferences for treatment course, the expected contributions of each partner to the process and any benefits each could hope to receive at outcome (Quill, 1983; Charles et al, 1999). The process of negotiation and agreement of a working contract has been defined as reaching a state of 'concordance' by some authors (Robson, 2002; O'Boyle, undated).

Some authors assert that concordant agreements foster a condition of parity or equality between the participants involved in the contract process (Coleman, 2000; O'Boyle, undated). This is perhaps concluded because the process of negotiating an agreement requires explicit joint discussion of the views and wishes of all parties. This concept seems to contrast with the process of compliance, which is defined as the act of following the orders or recommendations of a professional expert, such as a doctor (O'Boyle, undated). It is noted that the businesslike 'contractual agreement' of Quill (1983) may require particularly sophisticated communication and interpersonal skills from healthcare professionals and patients. It is also noted that the ability of the partners to speculate and assert their preferences and commitment in the partnership relationship might be dependent upon each possessing a good degree of 'self-awareness' (Feste, 1992).

One of the key rationales for developing the partnership model in the management of chronic conditions is to encourage and facilitate patient involvement and responsibility in their long-term care and treatments (Department of Health, 2001a; 2003). Greenwell (1996) defines the initiatives of patient involvement as 'citizen empowerment' and explains that the level of power that is required of patients can be divided into different models depending on how control of treatment is allocated. Let us examine the two key models of patient empowerment as they are discussed in Greenwell and other literature sources.

2.10 The evolution of the 'consumer' and 'expert patient' models of empowerment

2.10.1 The consumerist model

The concept of patient involvement in healthcare may be more easily conceived by the lay person as promotion of patient's rights to access their medical documents and this is something which has grown in significance in recent years (Coulter, 1997; Beutow, 1998). However, some authors suggest that patients' rights to participation in healthcare may be a much more complex issue and one that may be vulnerable to influence from social and power politics occurring within the ever-changing NHS (Coulter, 1997; Beutow, 1998). The writings of Coulter and Beutow show that official provision by the NHS to recognise and support patients' rights to a voice within the institution of healthcare came in the 1980's via the Patient's Charter. However, the level of power this intervention actually bestows upon patients is slight as it has to be ratified by the authority of the healthcare professional in charge (Coulter, 1997; Beutow, 1998). Thus, practitioners make the decisions concerning treatment and the patient's 'active' role is confined to the formality of approving the plans of the expert practitioner and submitting to treatment (Coulter, 1997; Beutow, 1998). The patient's involvement in this model would seem to be important mainly to 'legitimise' the plans and work of the health professional (Saltman, 1994). There does not appear to be any real recognition of the value of the patient's own views or power of choice in treatment although these may be sought informally during treatment.

The Patient's Charter initiative is described as an early form of patient consumerism (Greenwell, 1996). This is perhaps because it conceptualises the patient's health records as valuable resources which patients can bargain for much as they might in other social marketplaces. Coulter (1997) and Buetow (1998) suggest that not many patients can have accessed their health documents as this action is still dependent upon the approval of health professionals. However, the concept has undoubtedly shown patients in the British Isles that they might be able to obtain medical information if they have the right currency with which to bargain in the NHS institutional marketplace. Elliott et al (2003) discuss patient compliance with medication orders in the United States of America and comment upon the fact that a commercial healthcare system has been in force in the USA for many years. According to Elliott et al, in America's well-established consumerist system, patients expect to trade for the healthcare they want. Greenwell (1996) argues that patients as consumers are not obligated to become shared participants in their treatment since they are simply buying services they believe will help them. However, as Elliot and colleagues (2003) suggest, the consumerist model can force patients to comply with medical orders since purchase of treatment can obligate them to use the medication as directed and not to waste it.

These findings suggest that it is very difficult to separate the social power influences upon patients even when they seem to hold considerable bargaining power as the consumer. It is possible that Greenwell is wrong in her assumption that consumer patients do not have obligations in their commercial contracts with healthcare professionals because by entering into such a contract it could be argued that patients are agreeing to put themselves and their bodies under the complete control of the expert. What Greenwell (1996) does acknowledge correctly however, is that recognising patients as equal partners in healthcare decisions is a different concept from those promoted in the consumerist model. It is evident that patients as partners can gain some form of parity through the negotiation process wherein they can express their knowledge and views of their condition. Patients in the consumer role however, are not expected to aspire to any degree of expert knowledge or experience but simply to have the power to bargain for services they want or believe they need (Greenwell, 1996).

2.10.2 The expert patient model

More recently, the Department of Health (2001a; 2003) re-defined patients' rights in the NHS and extended the expectation of their role in healthcare. The patient's new role is broadly differentiated into participation at two levels: that of health service policy management and the patient's individual treatment (Department of Health, 2001a; 2003). The present study is concerned with the latter issue wherein patients are expected to become 'experts' actively contributing their own plans and choices in treatment and engaging in negotiation with healthcare professionals as to the most appropriate course of treatment (Department of Health, 2001a; 2003). This move seems to be a major development in the establishment of a more active and powerful role for patients in healthcare. This is because it promotes the concept of the 'expert patient' in recognition of the unique experience and knowledge patients can bring to the therapeutic process and the recognition of the importance of this in the management of 'incurable' chronic conditions such as stroke (Department of Health, 2001a).

There is some debate as to the legitimacy of the concept of patient 'expertise' and whether this can be considered as useful as the professionals' expertise in treatment (Prior, 2003; Wilson, 2001). In his objection to the concept of the 'expert patient', Prior questions not only the definition of patient expertise but also the practicalities of the patient's active role in partnership with healthcare providers. Prior asserts that he does not belittle the fact that patients possess experiential knowledge about their lives with disability or illness. However it is his view that this cannot grant patients the knowledge to make decisions about the best course for treatment and how this should be implemented. As far as Prior is concerned, this is still very much the domain of the healthcare expert. Wilson (2001) agrees that patients have no claim to the expertise held by healthcare professionals. However, she asserts that patients are capable of reaching common-sense rationalisations of their situation based on their own 'life-experience'. This suggests that patients have their own resources of knowledge and power which can be used to help them cope with their experiences in treatment. However, the nature of these resources and how they are used is not clear.

2.11 Conclusions and rationales for present research

The literature reviewed in this chapter illustrates the complex nature of the stroke physiotherapeutic treatment process. It also highlights the evident difficulties that therapists experience in trying to involve patients in their treatment and in communicating this with them in practice. The reasons for these difficulties still seem unclear. The literature seems to suggest that there are differences in the way that therapists and patients understand the purposes of physiotherapy treatment and their individual roles within it. It is evident from the literature that stroke physiotherapy treatment interaction is a complex social communication process incorporating elements of power which are not well understood. These uncertainties are likely to make the Department of Health's (2001a; 2003) plans to encourage partnerships between professionals and 'expert' patients difficult to implement in practice The rationales for the present research are therefore to clarify the factors in stroke physiotherapy treatment interactions which are preventing shared communication of treatment and to examine the social dynamics of how these influence the concepts of 'the professional' and 'the patient' and the development of partnership working.

2.12 General aims of present research

The aims of this research project were arranged in two main stages. The aims in the first stage were to conduct an exploratory study with physiotherapists working in stroke rehabilitation to identify therapists' views about therapists' and patients' understandings of the process of therapy and their roles in this process. The first stage study also endeavoured to identify the key problems preventing shared communication of treatment plans in practice and what therapists believed could be done to address these problems to promote more effective partnership working.

The first study revealed therapists' perceptions that patients conceptualised the goals and plans of stroke physiotherapy very differently from therapists and that they possessed different resources of power in their individual roles to strive for these goals. On the basis of these findings the second stage study aimed to conduct qualitative case studies to achieve an in-depth explanation of the power that was available to therapists and patients and how each used this power in the stroke physiotherapy treatment interaction in pursuit of their own goals. In conclusion, the second stage study sought to construct a model of the power dynamics in stroke physiotherapy to enhance understanding of the implications of power interactions on the development of partnership working.

Chapter 3 Methodology and methods

3.1 Introduction

This chapter will discuss the methodological approach and particular methods used in the stage one and stage two studies.

3.2 Justification of qualitative approach in social inquiry

This research inquiry sought to understand the social dynamics of the way in which therapists and patients work together in stroke physiotherapy treatment interactions and to identify the factors preventing shared negotiation and partnership working. The inquiry was carried out in two phases. Phase one comprised an exploratory focus group study with physiotherapists to find out how the aims and plans of treatment were conceptualised and communicated by therapists and patients during the course of treatment. This was intended to highlight the context of interaction and barriers to communication which inhibit shared negotiation and partnership working in stroke physiotherapy. The phase two study which followed utilised qualitative case study methods comprising direct observation of treatment sessions and follow-up interviews to construct an in-depth understanding of how the strategic use of power by therapists and patients in physiotherapy treatment interactions influenced the development of working 'partnerships' in practice.

Overall the research followed a qualitative inductive methodology because the data were assembled and analysed with the intent of developing an explanatory theory of a social phenomenon (Mason, 1996; Denzin & Lincoln, 1998; Hyde, 2000; Bryman, 2001). This approach contrasts with the more objective deductive perspective which is predominantly favoured in the quantitative research field (Denzin & Lincoln, 1998; Hyde, 2000; Bryman, 2001). As these authors state, in the latter approach data are used to confirm or reject a theory that is proposed before the study begins. This approach was inappropriate in the present study context because there was no clear understanding of how therapists and patients communicate about treatment or how they use power in their interactions to achieve their goals, thus the theory had to be constructed from the analysis of the data from the two studies in the project. However, the theory generative process did involve use of a priori knowledge in the development of the analytic interpretations of the data. As Eisenhardt (2002) and Denzin (2002) explain, the interpretative processes of developing explanatory theory in social research can involve the researcher considering the meanings of new data in conjunction with contextual background knowledge of the field. In the present study background reading on stroke physiotherapy and social power and communication provided the resources for development of the research questions and data collection instruments and these provided a degree of context to the interpretative analysis frameworks from which the theoretical models were built. According to Eisenhardt (2002) and Denzin (2002) this contextual knowledge can serve to develop more comprehensive understandings and explanations of the meaning of social phenomena.

Mason (1996) and Silverman (2000) support the assertion that a qualitative approach is appropriate in trying to examine and explain aspects of the complex social world because of the social perspective that is taken on what can be known and how this knowledge can be gained. This social approach enables the individual experiences and understandings of the participants involved in social events to be shared with the researcher and a detailed explanation of the dynamics to be constructed (Mason, 1996; Silverman, 2000). These social research perspectives will be discussed in more detail in the next few sections.

3.3 Justification of social constructionist ontological approach

The ontological perspective or model of reality that was taken in the research was 'relativist' or social constructionist (Bryman, 2001; Lincoln & Guba, 2002; Schwandt, 2003). In this approach to understanding, the basis of knowledge is a shared construct built from the multiple social realities experienced by the participants involved in the social phenomenon under scrutiny (Bryman, 2001; Lincoln & Guba, 2002; Schwandt, 1997; 2003). Social constructionist theorists argue that the social world is a dynamic phenomenon based in social relations and communication and this means it cannot be examined or understood from an objective standpoint using fixed truths (Schwandt, 1997; Gergen, 2001). Gergen (2001) in particular explains the importance of understanding the shared meanings that are developed in social interactions and how these can be used to understand the complex nature of therapeutic relations. The theoretical underpinnings of the social constructionist approach show that it was an appropriate model to use in the present research which sought to obtain the different interpreted realities of physiotherapists and stroke patients regarding communication and social power interactions in treatment to build a model of how these shared constructs shaped the roles of power and partnership in treatment.

The social constructionist approach was reflected throughout the study not only as the participants interacted in the focus groups and treatment sessions, but also as the researcher interacted with the participants in the different qualitative data collection processes and with the study's supervisors and therapist groups in discussion of the analytic interpretations of the findings. These complex interactions achieved shared interpretations of the relevant issues in the research from which explanatory models were constructed to answer the research questions about the nature of social power and partnership in physiotherapy treatment.

3.4 Justification of qualitative interpretive approach guiding the research methods

Quantitative research philosophies clearly lack sensitivity to the more subjective elements of the social world. This is because of the strongly held positivist epistemological stance which claims that the world can only be observed and recorded empirically, without human or social bias, as numerical or categorical data which can be interpreted statistically (Janesick, 1998; Bryman, 2001). In contrast, qualitative philosophies acknowledge the fact that understandings of the social world can be enhanced by drawing on the actors' own interpretations of the world – their views and experiences - which can be collected via tools such as individual or group interview methods for example (Janesick, 1998; Schwandt, 2003). Schwandt (2003) explains how the subjective interpretations of individuals can provide rich meanings from which in-depth explanations of the complexities of social phenomena can be developed. However, the influence of the researcher who interprets this information as it is collected and analysed must also be acknowledged as an integral part of the social event. Adler & Adler (1998) and Fontana & Frey (1998) note that qualitative research methods such as participant observation, focus groups and interviews utilise interactive processes to generate data (Adler & Adler, 1998; Fontana & Frey, 1998). As these authors discuss, this facilitates a shared interpretative epistemology where data are collected and analysed through the social interaction of the participants and the researcher.

These methods were appropriate in the present research which sought to construct an in-depth explanation of complex social processes which could only be understood in the detailed social medium of communication and interaction. Further to the social constructionist and interpretivist influences on the research and its methods, a symbolic interactionist approach was followed which enabled the meanings of power generated in the social interaction of therapy to be interpreted. This approach and its relationship with the social constructionist model will be explained in the next section.

3.5 Explanation of the symbolic interactionist approach

Symbolic interactionism is a psycho-social philosophical framework that is used to try to understand the complexity of social interaction in society (Charon, 1992; Schwandt, 1997). It is a complex perspective which harbours several theoretical models of social interaction and how this may be interpreted and applied in the research process (Charon, 1992). The symbolic interaction literature describes how the meanings that are generated in social interaction are negotiated between the individuals involved through verbal and non-verbal language (Charon, 1992; Schwandt, 1997; Poore, 2000). As Schwandt (1997) clarifies, language is essentially the communication of meaningful symbols. What makes the symbolic interactionist perspective so interesting and exciting however, is the dynamic and complex nature of the meanings that individuals generate in interaction. As Blumer (1969), in his summary of the work of George Herbert Mead reports, individuals interact with the symbolic elements they encounter in the world as they consider their meaning and decide how they should act. However, individuals not only interpret the meanings of their own perspectives as they interact with the world, they also construct the perspectives of others as they interpret them and act according to these perceptions (Blumer, 1969). From this description it can be seen that the symbolic interactionist approach is compatible with a social constructionist ontology because the reality that both relate to is a socially constructed one (Bryman, 2001). In the present research context, this reality was constructed from the symbolic social meanings interpreted by the physiotherapists, the patients and the researcher in the complex interactions in the focus groups, the observed treatment sessions, the individual interviews and in the analysis discussions. This shared interpretation of the reality of the symbolic meanings of communication and power and how they were used in stroke physiotherapy interactions contributed to the construction of an explanatory model which was developed as each new set of interpreted meanings emerged in the study.

This aspect of the symbolic interactionist approach was appropriate in the stage one study as the intention was to explore the interpreted meanings generated by therapists in group discussions of their own and patients' understandings of physiotherapy, the expectation of their respective roles in treatment and how difficult this was to communicate in practice. The stage two study took a more focused symbolic interactionist approach as it examined how therapists and patients interpreted and negotiated social power in physiotherapy treatment interactions to explain what this meant for partnership working. This approach required the researcher to have some understanding of the symbolic elements forming the basis of verbal and non-verbal communication in social interaction and how these were interpreted by individuals in everyday social life in order that the meanings of power could be interpreted in the data collection and analysis processes. Some evidence for the general elements of symbolic communication was found in the interpersonal communication literature. Literature was also found which outlined the tactile processes used in physiotherapy practice. These will be examined more closely with reference to their symbolic meaning in interaction next.

Hargie & Dickson (2004) describe how verbal communication can be interpreted on the basis of the meaning of the words spoken and the 'vocalics' or tonal and pitch aspects of the voice. They also outline a range of non-vocal communication mediums which individuals use in addition to more familiar verbal expressions to interact with and interpret their social contacts and situations in society. These consist of communication through the mediums of touch, expressive gesture or postural movement of the face and body and the use of physical space (Hargie & Dickson, 2004). In the process of human social interaction, these elements may be ambiguous in the meanings they convey to others (Hargie & Dickson, 2004). Moreover, this ambiguity may be enhanced in the complete absence of verbal qualification or in mixed cultural or generational interactions. In consideration of the present research context, it may be speculated that physiotherapy treatment interactions may demonstrate many of these non-verbal communication elements as physiotherapists often carry out tactile physical examination, passive movement and guidance of body parts as part of the physical therapy treatment process, much of which is carried out with little explicit verbal commentary (MacWhannel, 1992; Adams, 1994; Swain, 1997).

As Williams & Harrison (1999) and Swain (1997) observe, these physiotherapeutic activities also appear to relate to the theories of social control in the healthcare institution outlined by Foucault (e.g.: Foucault, 1982). However, it is still not clear how these non-verbal physiotherapeutic processes are communicated by therapists and perceived or interpreted by patients during the treatment interaction. From this discussion of the nature of symbolic communication it is evident that a symbolic interactionist research approach is appropriate to elucidate the negotiated and interpreted symbolic realities in the use and communication of power in stroke physiotherapy interaction.

3.5.1 Comparisons of symbolic interactionist and alternative perspectives

Research into the dynamics of social interaction has been carried out using the alternative analytic perspective of ethonomethodology (Schwandt, 1997; Holstein & Gubrium, 1998; Poore, 2000; Parry, 2001; 2004). A brief consideration of the different perspectives would be of value to clarify the justifications for the symbolic interactionist approach being the most appropriate to use in the present research.

The key distinctions between symbolic interactionist and ethnomethodological perspectives are the model of social interaction that is adopted for the analysis of social phenomena and the level of detail in the meanings that are derived from the interactive processes observed (Schwandt, 1997; Holstein & Gubrium, 1998; Poore, 2000). As these authors assert, both analytic approaches propose that understandings of the social world should be achieved through the interpretations and social constructions of those involved in that world. However, in contrast to the symbolic interactionist focus upon the meanings of the social world and how these are negotiated and constructed through the symbolic verbal and non-verbal social interactions of individuals, the ethnomethodological perspective is concerned with the content, 'structural patterns' and 'styles' of conversational interactions and what these say about the social world (Holstein & Gubrium, 1998; Poore, 2000; Drew, Chatwin & Collins, 2001).

The research focus of the present research is situated in stroke physiotherapy treatment interactions and is concerned with the unqualified rhetoric of the Department of Health's definitions of 'expert patients' and healthcare professionals becoming 'partners' in healthcare treatment (Department of Health, 2003). Overall, the study is examining the social meanings of 'the patient' and 'the professional' and how these are constructed, used and negotiated in the social reality of stroke physiotherapy treatment interactions as therapists and patients work towards their individual goals. It is hoped that this may lead to a better understanding of why shared communication and partnership working is difficult to achieve in practice and what could be done to support shared working in future.

Parry (2001; 2004) used an ethnomethodological approach in her study as she carried out conversation analysis on the interactions of therapists and patients in stroke physiotherapy treatment. There is no doubt that understanding the detailed structure of conversational interactions can provide a perspective on the complex social power relations underpinning physiotherapy treatment. However, it could be argued that the extreme focus of conversation analysis provides a specialised interpretative perspective more relevant to the physiotherapist than the patient. Parry's work did not seem to explain how the symbolic meanings of interactions in treatment are interpreted and used by patients and how this social interaction can influence therapists' actions. It is therefore important to examine physiotherapy treatment interactions from a less technical perspective to better understand patients' involvement in the social interactions and symbolic communications of treatment with therapists. It is concluded therefore that the symbolic interactionist approach is the preferred framework to use in the present research.

The particulars of the specific methods used in the different studies and their applications will be discussed shortly as the specific protocols of the two studies are presented individually. First, a brief explanation of the general ethics and sampling issues common to both studies will be provided.

3.6 Ethical and NHS approval

In accordance with good research practice, the two studies in the project were submitted for approval to the Ethics Committees and Trust Research and Development (R&D) departments governing the research sites chosen for the project. The phase one focus group study took place in three research sites and was approved by the Southampton & SW Hants, the Portsmouth & SE Hants and the East Dorset Local Research Ethics Committees. The phase two study which was conducted in two research sites was granted approval by the Portsmouth & SE Hants Committee. Full approval was also gained from the relevant Trust R&D offices in the different research sites where the studies took place. In accordance with this approval, both studies were conducted following the individual Research Governance and Data Protection frameworks in force at each site.

3.7 Purposive sampling

The sampling framework used in both the stage one and stage two studies was purposive sampling. This is a framework which is commonly used in qualitative research (Miles & Huberman, 1994). In this sampling framework, participants are chosen because they possess knowledge and experience of a particular social phenomenon which can be obtained through interview or observational methods to build an explanatory theory of an aspect in question (National Centre for Social Research, undated; Silverman, 2000). Purposive sampling was therefore considered appropriate in the present research context. In the stage one study senior therapists with experience of stroke physiotherapy were sampled because they could contribute views in the focus group discussions about therapists' and patients' understandings of the therapy process and their roles in treatment. In the stage two study therapists working in out-patient day hospital stroke physiotherapy and their patients were sampled to take part in qualitative case study inquiries of the treatment interactions in this setting. Demographic characteristics such as gender and ethnicity were not controlled in either study because these factors were not considered relevant in the research inquiry at this time. Patient age was controlled as a recruitment criteria in one research site in the stage two study to accord with the age-demarcation of stroke services in that Trust.

3.8 Stage one physiotherapist focus group study

3.8.1 General aims of the stage one study

Broadly, the aims of the stage one study were to utilise qualitative methods to explore the problems preventing shared understanding, communication and management of treatment in stroke physiotherapy from the perspectives of physiotherapists experienced in working in this field. From these data a research framework would be created for a follow-up study to examine the social dynamics of the physiotherapeutic treatment interaction in depth to determine its influence upon the development of partnership working.

3.8.2 Research design

The phase one study employed a focus group methodology and thematic analysis in a symbolic interactionist approach (Charon, 1992; Schwandt, 1997; Boyatzis, 1998). This approach facilitated the collection of the shared interpreted meanings of therapists working in stroke physiotherapy regarding their interactions with patients and the problems they felt underpinned the lack of shared communication in treatment.

3.8.3 Justification of focus group methods

The stage one study utilised focus group methods as its data collection method. The exploratory element in this study indicated that interview methods, preferably in a relatively unstructured format would be appropriate to discover the breadth and depth of meaning that the physiotherapists could provide about how treatment was managed and shared with patients in practice (Bryman, 2001; Janesick, 1998). Focus group methods have been said to be a more dynamic method of gathering qualitative data than that of individual interviews (Pope & Mays, 2000). The dynamic element in focus groups is the group interaction that occurs between the participants and the researcher who manages or moderates the group discussion (Kitzinger, 2000; High, 2000). This is a social communication dynamic which stimulates and develops the views and ideas of participants in accordance with the views of the rest of the group (Kitzinger, 2000; High, 2000). In one to one interviews the discussion is developed through interaction between the interviewer and the interviewee (Britten, 2000).

As a result of the different social interaction dynamics at work, focus groups and one to one interviews can produce different kinds of data and this can influence decisions of which method should be used in different research contexts (Millward, 1995; Kitzinger, 2000; High, 2000). In one to one interviews with a semi-structured questioning strategy it is possible for the researcher to achieve an in-depth examination of the participant's subjective understandings of the research topic (Britten, 2000). However, there is a risk that the participant may disclose personal information that is not appropriate to the study (Jones, 1991). Moreover, the researcher's interaction with the participant may adversely influence their ability to relax and contribute freely to the discussion (Britten, 2000). In focus groups, the views and ideas gained may be broader since the research topic will have been explored by the group members in discussion interaction and may express the group population's 'culture and social norms' (Kitzinger, 2000; High, 2000). Thus, focus groups may be useful tools to explore and identify more generally what issues of a social phenomenon may be important whilst individual interviews will be more able to achieve in-depth explanations of the meaning and relevance of these issues from the perspective of the individual (High, 2000).

Focus groups have been described as purposeful group meetings and this seems an ideal forum to explore the views of a group of healthcare professionals who are likely to be familiar with this as an in-service communication format (Millward, 1995). However, as Millward also noted, the group milieu could impose pressure upon participants. The potential impact of these issues upon the interaction of the group and the freedom of their responses was speculated to be quite high in a study sample of healthcare professionals who function in a hierarchical structure of authority. In view of this it was considered prudent for the researcher to be aware of these issues during the planning and implementation of the focus groups. These responsibilities are part of the researcher's moderator role in managing the focus group meeting. The role also involves the researcher introducing the topics for discussion, observing and listening to the group and facilitating members' active participation and interaction in the group discussion

(Bryman, 2001). The researcher's involvement with the group and the data is acknowledged in the use of this data collection method.

3.8.4 Physiotherapist sample

The sample populations for the focus groups in the stage one study were purposively selected because they were physiotherapists working in stroke rehabilitation (National Centre for Social Research, undated; Silverman, 2000). It was expected that the physiotherapists would be able to contribute views about the way that patients and physiotherapists understand treatment and communicate about this and perhaps ideas on how to help patients to become more involved in the process. The physiotherapists were recruited from convenient populations working in stroke rehabilitation services in three NHS Hospital Trusts across the south of England. They were approached using a modified snowball sampling technique (Bryman, 2001). A full description of the recruitment process is provided in section 3.8.5 in this chapter. In order to ensure that all of the physiotherapists in the focus groups had a broadly similar level of experience in the stroke rehabilitation field, specific criteria were used in the selection process. The main criteria, which were identified in discussion with senior clinical physiotherapists, were as follows:

Inclusion criteria

* Physiotherapists currently practising in stroke rehabilitation in hospital in-patient, out-patient or day hospital departments.
* Physiotherapists currently working at Senior II or Senior I grade.

Exclusion criteria

* Physiotherapists with no experience of stroke rehabilitation.
* Physiotherapists practising in domiciliary services only.

3.8.4.1 Grading criteria for senior physiotherapists in stage one study

I am not a physiotherapist and therefore had little understanding of the clinical grading system existing in physiotherapy. Very little literature appears to be available which clearly outlines the expected level of experience and skills necessary to carry out the roles of Senior II and Senior I physiotherapists. The Chartered Society of Physiotherapy website provided some information although details of the Whitley Council grading criteria could not be accessed (CSP, 2002). The data that was available was supplemented through discussion with clinical managers and superintendents in the physiotherapy departments involved in the study, who provided insight into the clinical experience and professional hierarchies existing in their departments. In these discussions it was found that physiotherapists working at Senior II and Senior I level would have had between two and six years' post-graduate clinical experience. It was also established that both senior grades would be specialising in neurological physiotherapy. However, Senior II physiotherapists would be consolidating their experience after two years at Junior grade and gaining experience working in rotation throughout the neurological clinical field whilst Senior I's would be established in a fixed clinical position (CSP, 2002).

3.8.4.2 Exclusion criteria

Junior physiotherapists were not included in the stage one study as it was expected that they would have had no more than four months experience in stroke rehabilitation as part of their junior clinical practice rotation (CSP, 2002). It was also considered important to exclude the more senior superintendent grade physiotherapists as it was thought that they may be perceived as authority figures by the Senior II or I therapists which may potentially constrain the discussion and interaction in the focus groups (Fleming & Golding, undated). Domiciliary therapists were also excluded from the study. This was done on the basis that as domiciliary therapy takes place in the patient's own home environment, the treatment process and the participant's understandings and roles may be different to that taking place in the hospital setting.

3.8.4.3 Sample size

Six focus groups were planned and conducted within the physiotherapist study on the rationale that these would provide sufficiently rich data to achieve theoretical saturation (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Theoretical saturation marks the end-point of data collection in the iterative grounded theory process at the stage where the data being generated are unable to contribute anything new to the theory (Strauss & Corbin, 1990). Although the study did not follow a grounded theory approach, this principle was used as a guide to manage the completion of data collection in the focus groups. A seventh group was conducted at the end of the data collection period in order to invite the opinions of physiotherapists on the theoretical conclusions being developed in the analytical framework of the study. The numbers of participants within each group was planned to be between five and ten in order to facilitate satisfactory group interaction and discussion. The numbers of participants in each group are set out in the following chapter.

3.8.5 Recruitment of physiotherapists

Physiotherapists for the focus groups were recruited from three NHS Hospital Trusts across the South of England. The clinical managers of the physiotherapist services within these Trusts were contacted and permission to approach physiotherapy staff working in the departments was obtained in writing. Superintendent physiotherapists from each Trust's stroke physiotherapy services were identified through the clinical managers and letters introducing the study were sent to each (copy of letter in Appendix B). The superintendents were asked to distribute information sheets describing the study to the Senior II and Senior I physiotherapists working in their departments. A copy of the information sheet can be seen in Appendix B.

A visit was arranged to each of the physiotherapy departments to speak to physiotherapists who learned about the study from superintendents or colleagues. The physiotherapists were accessed conveniently from existing clinical service populations and informed about the study via a modified snowball sampling technique cascading from the initial approach made to the superintendents (Bryman, 2001). All interested participants were encouraged to take the information sheets away to study in their own time. Consent forms were also distributed (copy in Appendix B). A contact telephone number for the researcher was also provided in order that participants might seek further information if required. No incentives were offered. The physiotherapists were told that if they were happy to take part in the study they should complete, sign and return the consent forms to the researcher in the reply paid envelope provided. A small number of therapists attended the focus group meetings having just returned from holiday. These therapists had been given copies of the information sheet by colleagues to read and consider before attending the group. They were given the consent form to sign on the day of the meeting prior to the group commencing.

3.8.6 Focus group procedure

The focus group meetings were arranged in association with the superintendents within each department. All the groups took place at a convenient venue within the physiotherapy departments over the period of the physiotherapists' lunchtime break. The groups lasted between thirty and sixty minutes, the mean duration being forty-four minutes. No clinical work was impeded as a result of the groups taking place or the physiotherapists' participation. Light refreshments were provided. The meetings were run by me as moderator. An academic colleague whose role was to act as a silent observer, taking note of the group's interaction processes also attended. The three colleagues who shared this role throughout the data collection period were a postgraduate psychology student, a postgraduate speech therapist and a sociologist senior research fellow who is also supervising the study. The group discussions were all audio-taped with participants' express permission. After I introduced myself and the observer to the group, a brief summary of the study and its purpose were given. Information was provided on how the group would be run and advice given on the basic rules of the focus group process to maximise the effectiveness of the discussion interaction and audio-recording and to ensure the participants were comfortable during the activity. As the focus group participants were sourced from existing hospital clinical service populations, members in each group were familiar to each other as colleagues. When the tape recorder was switched on the group commenced and questions were begun from a broad exploratory vein then focused in on important issues as these were raised during the progress of the group. At the end of the meetings, a brief summary was given of the key issues that had been discussed and the groups were invited to add any additional information or comment on anything that should be explored in future groups. It was considered that this process might provide some validation of my immediate interpretations of the discussion's content.

3.8.6.1 Development of the topic guide

A brief topic guide focused on the research questions was used as an aide-memoir to ensure that key issues were explored in the focus group discussions. The topic guide used in the first two focus groups was informed by the literature and discussions with senior academic physiotherapists. After each subsequent focus group the topic guide was developed to include key issues which had been raised which could be explored in the next group discussion. A copy of the topic guide and an outline of how it was developed during the focus groups are lodged in Appendix C.

3.8.7 Data management and transcription

As soon as possible after each focus group had taken place, the audio-taped discussion data were reviewed and transcribed whilst the experience of the event was still in recent memory. This enabled any key issues that had been noted in the observer and moderator field notes to be written up in detail and referenced to the taped data as it was transcribed. It also helped in the clarification of areas of the taped discussion that had recorded badly and were difficult to hear. Next, the taped discussion data were rendered into a state in which they could be subjected to analysis. The tapes were transcribed verbatim by me into Word documents which were rendered anonymous by the omission of any personal or locality identifiable information from the transcripts. Parts of the discussion were indecipherable on the audio-tapes and these sections of missing data were highlighted by closed brackets thus: (   ). Where possible, each separate voice on the transcripts was identified by a letter and number code thus: M1. (moderator) and P.1. (participant 1). However, it was found to be extremely difficult to separate participants' voices in some of the groups due to the liveliness of the discussion and quiet voices.

Each focus group transcript was labelled with a number and date and all tapes when not in use were stored in a locked cabinet. Huberman & Miles (1994) attest to this processing activity being the beginning of an ongoing data management system which should ensure quality and ease of accessibility of data in all transitional forms. The systematic management of data throughout the study is also considered essential to ensure documentation of a 'data trail' (Huberman & Miles, 1994). It also represents the beginning of the formal analytical process whereby the data are developed and interpreted to facilitate conceptualisation of overt and underlying meanings which will add detail to the developing theoretical picture (Huberman & Miles, 1994; Boyatzis, 1998). In the present study, this took the form of thematic analysis which was conducted using a symbolic interactionist approach (Boyatzis 1998; Bryman, 2001).

3.8.8 Analysis of the data

The transcribed focus group data were analysed in essentially three ways – 'interpretative analysis' to uncover meanings, literal appraisal of the dynamic structure as a discussion and 'reflexively' to acknowledge the centrality of the researcher in the analysis and development process (Mason, 1996). In this respect, it is clear that 'the data' involved more than just the focus group transcripts. The focus group observation notes were used to provide interaction and contextual details of the discussion and the meeting itself where possible. This was important to ensure that the researcher's developing interpretations were linked with the interactive group discussion in which the data were collected (Catterall & Maclaren, 1997). Similarly, the researcher's field notes and memos documenting the study's analytical and theoretical development indicated the way the research process was grounded in the researcher's thinking and interpretation (Strauss & Corbin, 1990).

The process began with the interpretative thematic analysis of the data which was carried out initially using the Ethnograph Qualitative Data Analysis Software (Seidel, 1998). Qualitative Data Analysis programs like the Ethnograph are reported to be useful tools in facilitating the organisation, manipulation, development and recording of the operations involved in the analysis of qualitative data (Seidel, 1998; Ryan & Bernard, 2000). Ethnograph was used because it introduced a level of formatting within the transcripts and codebook which was easy for the inexperienced researcher to use. This data management system was continued when the analysis was later manually operated. In this respect, the computer-aided process probably contributed to the quality and 'consistency' of the analysis (Boyatizis, 1998).

3.8.8.1 Justification for the use of thematic analysis

Thematic analysis is upheld as a useful analytic tool for dealing with qualitative data (Boyatzis, 1998). Broadly, it involves the data being scanned and developed on various levels to bring out overt and underlying meaning through the development of interpretative codes, clusters or patterns and higher order themes (Boyatzis, 1998; Attride-Stirling, 2001). It is a systematic process and for this reason could be said to be similar to the analytical processes of grounded theory (Strauss & Corbin, 1990; Attride-Stirling, 2001). However, thematic analysis appeared to be less propositional and more intuitive in its process compared with grounded theory analysis methods. Moreover, since the interpretation of meaning of the data and the construction of the higher order themes was based to some extent upon the researcher's a priori understandings of the research field and also the shared symbolic understandings of the participants and the researcher through the interactions in the study procedures, grounded theory was inappropriate because the explanatory theory was not being developed from the data alone. (Eisenhardt, 2002; Denzin, 2002).

3.8.8.2 Analytical coding and higher theme development

The transcripts were read through line by line and codes were identified which related to the themes broadly conceptualised by the research questions (Coffey & Atkinson, 1996). The codes were identified in two ways – either from concrete statements made in the data or from abstract ideas suggested by the statements and interpreted by the researcher on the basis of a developing theoretical insight or sensitivity (Glaser, 1978; Seidel, 1998). Eisenhardt (2002) and Denzin (2002) suggest that theory in qualitative research is constructed from multiple sources of interpretation and these can be derived from the data, from prior knowledge and from the context of the social event. In the present study the theoretical interpretations were constructed from meanings interpreted from reading the data transcripts and from a priori meanings drawn from the research questions which were derived from the researcher's understanding of the background literature of the research topic. The contextual relevance of the theoretical interpretations was confirmed in discussions with some of the therapists who participated in the study. The segment of text which related to the code was highlighted and labelled within the text and the code word entered into a codebook within the Ethnograph software, with a definition which described its parameters and particular theoretical application. The codebook was used as a framework in the coding of subsequent transcripts and in this way, its theoretical relevance to the research phenomenon developed also (Boyatzis, 1998). The Ethnograph program facilitated the development of a hierarchy of codes in a family tree format which enabled relationships and differences to be identified between codes (Seidel, 1998). It also began the process of clustering in the data, which led to the development of higher order codes and themes (Boyatzis, 1998).

The Ethnograph program contained the facility to summarise coded data segments by single or multiple code words, but it was found more practical to brainstorm the cluster analysis of the codes by hand. Printed copies of the coded and labelled transcripts were spread out on a table, cut into individual coded data segments which were collected together by code word. The collated code segments were re-read and connections with other codes were created on the basis of related characteristics (Boyatzis, 1998). The larger concepts or themes which developed from this process were more meaningful in the research context and this interpretative strength was illustrated by inclusion of relevant quotations from the codes which together created the dimensions of the themes. An example of a theme and two of its sub-themes which emerged from the data are shown in Figure 1 along with illustrative quotations.

Figure 1. Interventions to support shared understanding in treatment plans

Code: Contract

FG PT 2: *" What we'll sometimes do, if you've got someone who's actually obviously quite cognitively alert, is almost get a contract between you when you're doing the goal setting.."*

Code: Com-video

FG PT 4: *"You can video them and then treat them for a few weeks then video them again and then show them the video and so you can say, look this is what...how you were walking before and this is how you're walking now.."*

3.8.8.3 Credibility of analysis interpretations

Lincoln & Guba (1985), Mays & Pope (2000) and Koch (2006) note that it is important to establish the credibility of interpretations reached in the analysis of qualitative data to ensure that they are meaningful in the context of the social event to which the theory relates. The authors suggest that this can be achieved through presentation of the theoretical explanations to the research participants or similar individuals to invite feedback on how relevant they are to their own experience in context. In the stage one study this was achieved by the running of a seventh focus group with a new group of senior physiotherapists working in stroke rehabilitation. In this group the early interpretative conclusions drawn in the six focus groups were discussed. This served to clarify and focus the interpreted meanings in the data and assisted in the development of the higher order themes by confirming the credibility of the meanings in the experiences of the physiotherapist group. The participants for the seventh group were recruited from one research site following the same sampling and inclusion criteria. The group was conducted in the same manner as the previous groups. Further discussion is made in sections 3.9.10 to 3.9.10.4 regarding the criteria by which the quality of the research was judged and the strategies that were employed to ensure this was maintained throughout the research process at all stages.

3.8.9 Summary

This concludes the presentation of the methods specific to the stage one study. Discussion of the general methodological processes common to both the stage one and stage two studies will be made at the end of this chapter. First however, the specific methods used in the stage two study will be presented.

3.9 Stage two case studies of therapy treatment interactions

3.9.1 Aims of the study

The aims of this study developed from the conclusions reached in the stage one focus groups. This study revealed that unequal and often conflicting issues of 'understanding', 'power' and 'communication' in the physiotherapy treatment interaction were influencing the way that patients and therapists worked together. As this is likely to have implications for the partnership relationship between the participants in treatment, it was therefore essential to develop a better understanding of what these powerful social influences were and how they were used by the patients and therapists in treatment. To this end, the aims of this second study were threefold: firstly, to examine how patients and therapists used strategies of power in out-patient stroke physiotherapy treatment interactions as they each strove for their individual goals in treatment; secondly, to establish how these strategies were understood and communicated between them during treatment and thirdly, to identify how the individual strategic activities of the therapists and patients influences the development of partnership working in the treatment interaction.

3.9.2 Research design

In order to achieve these aims, the phase two study utilised a multiple qualitative case study methodology following a symbolic interactionist approach. Each case study comprised direct observation and tape recording of an out-patient stroke physiotherapy treatment interaction and follow-up interviews with the therapist and patient involved. This design was appropriate in the present research context as the inquiry was focusing upon the social and psychological dynamics of human interaction with particular reference to the symbolically defined meanings generated within the interactive process and how these influence the relationship between the social actors involved (Schwandt, 1997; Janesick, 1998).

3.9.3 Justification of qualitative epistemologies in phase two study

It is expected that the direct observations and semi-structured interview methods in the stage two case studies will be true to a qualitative social interpretivist epistemology and will capture the rich interpretations of the symbolic interactions and understandings of the participants in the stroke physiotherapeutic treatment interaction (Janesick, 1998; Schwandt, 2003). It is possible to apply observation methods in a more objective manner (Janesick 1998; Bryman, 2001). However, a quantitative and positivist epistemology such as this was considered inappropriate in the present research context. This is because positivist approaches, with their insistence on the absolute validity of measurable data with the minimum of human bias would be likely to reject the looser socially interpreted epistemology which is considered a central feature in the study of social interaction (Charon, 1992; Gherardi & Turner, 2002; Schwandt, 2003). The production of categorical statistical data of the interaction activity would contribute little to understanding the immediacy of the complex social elements which shape and drive the interaction.

3.9.4 Justification of case study methods

Case studies are reportedly a popular research method in the social science and healthcare research fields (Schwandt, 1997; Seale & Barnard, 1998; Stake, 2000; Yin, 2003). But as these sources also suggest the complex and multifunctional nature of case studies can mean that they can be difficult to understand and challenging to use at times. Case studies are generally used by researchers as they try to unpick and elucidate the often 'messy' nature and social dynamics of particular events and phenomena in the real world (Keen & Packwood, 2000). In using case studies, researchers are able to focus upon one or more instances or 'cases' of a particular event or phenomenon with the intent of acquiring a detailed snapshot of its specific dynamics, including its social and psychological influences within that particular setting (Keen & Packwood, 2000; Stake, 2000; Yin, 2003). It is important to recognise that as a research strategy with such a specific focus, case studies are not designed to produce data which can be generalised to other social contexts. However, as Keen & Packwood (2000) and Yin (2003) acknowledge, in the context of qualitative research, detailed illustrations of specific events or phenomena and their dynamics and problems in the social world may be more informative.

Qualitative case studies typically involve direct observation and interview data collection strategies (Stake, 2000; Yin, 2003). Both Yin (2003) and Stake (2000) asserted the importance of planning case studies in detail to ensure employment of the most appropriate strategies for particular research questions and purposes. This may be considered good research practice. It also echoes the teachings of Mason (1996) who upheld the need to clearly establish the underpinnings of research before embarking upon more specific methodological decisions. The rationales of the observation and interview methods and consideration of their appropriateness in this study will now be addressed in more detail.

3.9.4.1 Direct observation methods

As part of the case study design, direct observation and audio-taping of six out-patient (Day Hospital) stroke physiotherapy treatment interactions was carried out. Conducting direct observations of social events as they happen in their natural setting can provide insight into the immediate circumstantial and social symbolic realities of interactions including how they appear to be communicated between the participants (Yin, 2003; Pole & Lampard, 2002). In planning to use observational research methods, it is suggested by several sources that certain key issues need to be considered (Burgess, 1993; Seale & Barnard, 1998; Atkinson & Hammersley, 1998; Pole & Lampard, 2002). These issues are: how the observations will be carried out and recorded; who would be conducting this role; how involved the observer would be in the process and how this might influence the actions of the participants and the credibility of the data.

In the present research context, the observer was the main researcher. Many primary sources of literature dealing with observational research methods (e.g.: Burgess, 1993; Atkinson & Hammersley, 1998; Pole & Lampard, 2002) cite the work of Gold (1958) who created a typology for the involvement of the observer which ranged from total immersion in the interaction to a completely objective non-participatory stance. As these texts explain, it is difficult to separate the observer from the interaction taking place particularly if they are situated in the same room and the participants are aware of being observed. An additional factor in the present research was that the physiotherapist participants worked with the researcher in the recruitment of patients for the study. It is possible that this prior role as co-recruiters in the study may have influenced the therapists' attitudes to the surveillance of their work activities during the interactions. The observed sessions were also audio-taped with the participants' permission. This was considered appropriate to obtain a record of the verbal interactions in the treatment processes to provide a useful adjunct which would contribute to the interpretation of the observed interactions of the participants in the sessions. Other researchers in the field of physiotherapeutic interaction have used video-taping to record treatment interactions, for example: Talvitie & Reunanen (2002). However, it is notable that this research involved a conversational analysis framework, which requires the fine visual detail that audio-taping obviously cannot provide (Holstein & Gubrium, 1998; Talvitie & Reunanen, 2002). As this level of detail was not considered necessary in the present research, the use of video-tape recording was not used. Moreover, the use of video-recording techniques might have affected the participant's comfort more than audio-recording.

3.9.4.1.1 Development of an Observation Instrument

Because direct observation of social interaction is an immediate and dynamic process which is literally unfolding before the observer's eyes, it was acknowledged to be advisable to have a plan or a framework regarding what the observer should look for (Seale & Barnard, 1998; Pole & Lampard, 2002). As these authors explain, this could be done in the form of an observation schedule or instrument which could be used to guide the observer's activities through the observational process. It was expected that this instrument would structure the field-note taking process during the observation sessions and produce a valuable and accessible shorthand record which could be employed later in the interpretation and analysis processes.

The Observation Schedule for the present study was constructed after consideration of the observational methods, physiotherapeutic and inter-personal communication and power interaction literature (Seale & Barnard, 1998; Williams & Harrison, 1999; Hargie & Dickson, 2004; Pole & Lampard, 2002; Coleman; 2000; Deutsch, 2000). A model of the key elements of general interpersonal non-verbal communication was identified from the work of Hargie & Dickson (2004). This was adapted to form a range of non-verbal symbolic meanings that may communicate the use of power strategies in physiotherapeutic treatment interactions. The key elements in the Schedule after Hargie & Dickson are: 'Power in the use of physical space'; 'Power in the use of body movement'; 'Power in the use of physical touch,' and 'Power in the (non-speech) use of the voice.' The Schedule also incorporates a section to assess the co-operative nature of the treatment interaction (Deutsch, 2000; Coleman, 2000) and space to sketch the physical layout of the treatment space and space to record demographic details of the age, gender and dress of the patients and physiotherapists. As Williams & Harrison (1999) assert, the variables of age, gender and dress may be perceived as impositions of power in the physiotherapy treatment setting. A copy of the Observation Schedule is in Appendix D.

Seale & Barnard (1998) and Pole & Lampard (2002) note that it is important to pilot any observation instrument and the observation process itself for several reasons. The first reason is to establish the observation tool's relevance to the intended purpose of the research and the observations. The second reason is to enable the researcher to practise using the instrument and to fine tune observational skills in the research environment (Seale & Barnard, 1998; Pole & Lampard, 2002). The third reason is the opportunity to run through the recruitment and data collection processes. Pole & Lampard (2002), note that these tests can be achieved by carrying out a small pilot study with a small sample of participants who meet the study criteria.

In the present study, constraints of access to stroke physiotherapy treatment sessions for the pilot study and time availability concerns led to the observation instrument and the researcher's observational skills being piloted in a less formal but no less satisfactory manner. To conduct the pilot process, the researcher obtained permission to access a library of videotaped stroke physiotherapy treatment interactions held in the physiotherapy department in the local NHS Hospital Trust. These videotaped treatment interactions were established by the physiotherapy department with the permission of patients for student and staff training purposes. In this respect, it was considered that the student researcher's use of this resource was appropriate for the assessment and practice of the use of the observational instrument and process in the study. The researcher was supervised in her use of this material and no patient identifiable information was accessed or recorded.

The eight video-taped stroke physiotherapy treatment activities observed all took place in a physiotherapy gymnasium setting and involved one or more physiotherapy personnel, the clinical grades of whom were not identifiable. The eight patients, seven men and one woman, were all mature individuals who were being treated by female physiotherapy staff for stroke-related impairments. The ages and specific diagnoses of the patients were not identified.

The observed video-taped treatment activities highlighted useful issues regarding how the observation schedule should be used and how this should be documented without interrupting the flow of observations. In this respect, it seemed more practical to use the prepared schedule as a structured 'prompt' to observation rather than as a strictly systematic observation tool. It was decided that using the schedule to record immediate notes, layout plans and jottings would enable notes to be made on what was taking place without the researcher's attention being removed from the on-going interaction. It was considered inevitable that some interactions would be missed during the session if detailed notes were taken. Thus, it was planned that annotations of time and line sketches of the use of space, movement and touch would be made for later consideration. These rough notes could then be referenced against the audio-taped record after the session and written up more fully.

3.9.4.2 Semi-structured interview methods

In addition to carrying out direct observations of the interactions in the physiotherapy treatment sessions, follow-up interviews were also conducted with the therapists and patients involved in the sessions. The interviews were an important part of the case study methods as they enabled issues identified in the observation sessions to be followed-up and discussed directly with the participants of the treatment sessions. The rationales of the use of interviews as a general research method have been discussed briefly in section 3.8.3 with reference to the stage one study methods. However, as their application in the stage two case studies would involve their use with participants who had suffered a stroke and may have cognitive or communication difficulties, it is necessary to consider the implications of this method in these special circumstances.

This is also important since the follow-up interviews intended to examine abstract topics such as aims and power strategies, which patients might have had difficulties dealing with.

The interviews were intended to be conducted in a semi-structured fashion, which meant that the interviewer directed questions to the participants in an open-ended structure to encourage in-depth discursive examination of the inquiry topics in detail. The one to one interaction between the interviewer and the participants meant that if understanding or communication were difficult, then support could be given in the form of more structured questions or more time. As Philpin et al (2005) acknowledge such supportive flexibility in the interview structure is important in studies involving participants with communication difficulties to enable them to contribute fully in the research. Philpin et al note that the research methods literature offers scant advice about conducting qualitative interviews with participants with cognitive and expressive communication difficulties. However, on the basis of an interview study conducted with patients with impaired communication, Philpin et al conclude that allowing extra time, enlisting the help of family and using other modes of communication such as pictures and written answers can support the participation of patients in the interview process.

Because of their flexibility in being able to include and support the participation of individuals with communication impairments, it seems clear that interview methods were an appropriate tool to use in the case study processes to achieve the depth of inquiry about the power interactions in the treatment sessions.

3.9.5 Selection of participants for the primary case studies

The participants for the case studies were selected on the basis of 'the case' or the particular social phenomenon under scrutiny in the study (Stake, 1998; Yin, 2003). The 'case' in the present study was the out-patient stroke physiotherapy treatment dyad as this was the interaction which the study was focusing on to examine the strategic power interactions and their influence on partnership working. For the purposes of this study, the participants were therefore patients currently undergoing physiotherapy for their stroke event and their out-patient physiotherapists. In this respect, the participants were purposively sampled to obtain working examples of stroke physiotherapy treatment interactions (National Centre for Social Research, undated; Silverman, 2000).

The patients and therapists were further screened for the study on the basis of basic inclusion criteria. This was done to work in accord with the rehabilitation service's treatment differentiation system which was distributed according to patient age. It was also implemented to ensure that certain factors which could influence the interaction between the therapists and patients in the individual case studies were standardised, such as the number of stroke events the patient had experienced and their treatment experience. The therapists eligible for the study were identified by the superintendent physiotherapist and if happy to consider participation in the case studies, were invited to identify those of their patients who met the basic inclusion criteria for the study. The inclusion criteria for the patients and therapists in the case studies were as follows:

3.9.5.1 Patient inclusion criteria:

* Currently receiving out-patient (day hospital) physiotherapy treatment following first stroke
* Received a period of in-patient physiotherapy treatment following first stroke event
* Aged 65 years and over

3.9.5.2 Physiotherapist inclusion criteria:

* Currently working as trained physiotherapist in out-patient (day hospital) stroke physiotherapy service
* Qualified physiotherapist of any grade.

3.9.6 Recruitment of participants for the primary case studies

Prior to recruitment activities taking place the study was granted the approval of the Portsmouth & SE Hants Local Research Ethics Committee and the local Research Governance Committee. A copy of the main ethics approval letter is located in Appendix A. The patients and therapists for four of the case studies were recruited from the over-65 (day hospital) stroke physiotherapy service in the 3 Primary Care Trusts of one regional Health Trust. Participants for a further two case studies were recruited from the day hospital stroke physiotherapy service in an affiliated NHS Trust which was set up as additional research site with the full approval of the Local Research Ethics Committee and the Research Governance Committee in that Trust. There was no age stipulation for the stroke patients in this additional day hospital rehabilitation service. No incentives were offered to any of the participants to take part in the study.

3.9.6.1 Negotiating access in the clinical setting

Permission to conduct the study recruitment and case study activities in the research sites identified was sought from the relevant senior clinical managers. The Consultant Geriatricians responsible for the stroke services at the chosen research sites were informed of the study and invited to grant their consent for the study to proceed in their areas. In total, six of the nine Consultant Geriatricians granted their approval for their patients to be approached about taking part in the study. A copy of the introductory letter and consent form sent to the Consultants is in Appendix E. The researcher liaised frequently with the stroke services physiotherapy superintendent regarding the study recruitment activities. This was an extremely valuable assistance which facilitated communication with the over-65 out-patient stroke physiotherapists across the service day hospitals and enabled co-ordination of the therapist's activities in the different recruitment processes.

3.9.6.2 Physiotherapist recruitment process

Physiotherapists working in the over-65 out-patient (day hospital) stroke physiotherapy treatment services of the Primary Care Trusts involved in the study were identified by the stroke services superintendent physiotherapist. These individuals were sent a letter introducing the study asking them if they would consider participating in the case studies with their patients and if they would be happy to assist in the identification of eligible patients from their current treatment lists. They were also given an information sheet which explained what participation would involve for the physiotherapists. Copies of the Physiotherapist Introductory Letter and Physiotherapist Information Sheet are in Appendix F. Those therapists who were happy to participate in the study and to assist in the patient recruitment process were invited to complete and sign the two copies of the Physiotherapist Consent Form which were enclosed and to return one copy in the pre-paid envelope provided retaining one copy for their own reference. A copy of the Physiotherapist Consent Form is in Appendix F. Upon receipt of the therapist's completed consent forms, the researcher liaised with the relevant individuals on a regular basis in order to facilitate the progress of the patient recruitment activities.

3.9.6.3 Patient recruitment process

The patient recruitment process was originally set up to identify and recruit patients for the case studies from the in-patient stroke physiotherapy services. However, whilst this was deemed to be a feasible and ethical method of recruitment, it failed to make progress, perhaps due to it being rather time consuming for the in-patient therapists to manage within their pressured clinical schedules. Accordingly, the study sought an amendment from the Local Research Ethics Committee and instigated a protocol to identify and recruit patients directly from the out-patient physiotherapy service with the agreed assistance of the therapists working in the day hospital rehabilitation service. Whilst this new method of recruitment meant that patients would be approached about taking part in the study by the therapists who were treating them and consequently may have some influence over their decisions for participation, it was for practical reasons deemed to be the only way to proceed with the study.

Following this amended protocol, the day hospital therapists identified patients from their treatment lists who appeared to meet the criteria for the case studies. As part of this introductory process, the therapists provided interested patients with an information sheet which explained about the study. Attached to the information sheet was a response form which patients were invited to complete to indicate their interest in finding out more information. Copies of the Patient Information Sheet and Preference for Information response forms are in Appendix F. Patients were asked to provide their contact number on the response form and to post this to the researcher using the pre-paid envelope provided. Those patients who expressed an interest in the study on their response form were contacted by the researcher and visited by her to discuss the study and what participation would involve if they were happy to take part. The researcher then obtained written consent from patients who wanted to take part using a specific Patient Consent Form prepared for this purpose (copy in Appendix F). The GP's of patients who took part in the study were informed with the patients' consent (copy of GP letter is in Appendix F).

3.9.7 Case study procedures

3.9.7.1 Out-patient treatment observation sessions

As soon as the therapists and patients had given written consent for their participation in the study, the researcher consulted with them and agreed a suitable treatment session for the study observation session to take place. The observation sessions all took place in the out-patient physiotherapy treatment gymnasiums of the day hospitals in which the patients normally received their treatment. Until the day of the treatment session arrived, the researcher maintained weekly telephone contact with the therapists and patients in case any problems occurred which may have influenced the study's plans. On the day of the treatment session, the researcher checked that both the therapist and patient were happy to proceed with the observation session and both were reminded that they could suspend the study's scrutiny of the session at any time if they felt uncomfortable.

The participants were reminded that the session would be audio-taped and a suitable place for the tape recorder and the researcher to sit was agreed in discussion with the therapists and patients. This was done to achieve satisfactory observation and audio-recording of the interaction with minimal disruption to the activities of treatment and the well-being of the participants. The recorder was generally situated on a stable surface such as a treatment bench or a chair roughly four to eight feet away from the therapist and patient as they worked together. The researcher was seated on a chair approximately ten to fifteen feet from the therapist and patient in a position which offered a good view of the treatment interaction. It was sometimes necessary for the position of the recorder and/or the researcher to be changed during the sessions as treatment often involved movement to another part of the gymnasium to use a different piece of equipment or moved into another room. Repositioning of the recorder and/or the researcher was only carried out if absolutely necessary and was done during the preparatory phases of the treatment activities with the approval of the therapists and often at their suggestion. Any other therapist-patient groups who were working in the day hospital gymnasium at the same time were approached, briefly introduced to the fact that a tape recorded study was taking place and advised that any recordings of their voices would not be used in the study. Upon completion of these necessary formalities, the tape recorder was switched on and the observation session begun.

The time of the start of the session was noted by the researcher on the prepared Observation Schedule along with sketches of the layout of the treatment area and the participant's movements within these spaces. The Observation Schedule, which was described in detail in section 3.9.4.1.1 of this chapter, was used by the researcher to identify and record instances of strategic power negotiations taking place between the therapists and patients as they worked together in treatment. The strategic power negotiations were identified as interactions where the therapists and patients negotiated control with each other in their different ways to try to achieve what they wanted. The negotiations were conducted in various non-verbal and verbal communication mediums including physical touch, physical movement in space, social humour, discussion and persuasive argument. The different negotiation strategies used by therapists and patients were chosen by them on the basis of the individual understandings they had of the interactions from their different roles and experiences. Thus, for example, the therapist's use of tactile control of the patient's bodies was recorded as a negotiation in the physical medium and the patient's use of bashfulness was identified as a negotiation in the social medium. The verbal interactions that were simultaneously recorded on audio-tape during these sequences were also used to provide further interpretative meaning of the participant's aims in their strategic actions and responses. The observations and recordings ended when the patient was preparing to leave the treatment area. At the end of the session, the study participants were debriefed in order to answer any questions they had.

3.9.7.2 Follow-up interviews with participants

At the end of the observed treatment sessions the researcher spoke separately to the therapists and patients to agree the date, time and venue arrangements for the follow-up interviews. If the therapist had another patient to see at this time, such arrangements were made at a later time by telephone. The therapist interviews took place at the day hospital sites at a convenient time which did not interfere with the therapist's work. The patient interviews were held in their homes with their permission at a time which was convenient to them. Patients' relatives were not intended to be involved in the follow-up interviews. It was planned that the follow-up interviews with the patients and the therapists should take place as soon as possible after the observed treatment sessions in order to support the participants' recall and discussion of the interaction events that had taken place. The patient interviews were conducted between three and seven days after the observed treatment sessions and most of the therapist interviews between seven and twelve days. One of the therapist interviews took place twenty-nine days after the treatment session due to other priorities that the therapist had to deal with. This longer elapse of time did not appear to constrain the therapist's participation in the interview discussion although she did refer to her treatment notes occasionally to clarify details of the treatment event. Some of the patients experienced occasional difficulties in recalling the details of what took place in the treatment sessions. It was not clear whether this was due to the elapse of time or the influence of stroke or age-related cognitive difficulties. When discussing the patient's understandings of key interaction events which took place in treatment the researcher would refer to the session's field notes and audio transcript data to provide basic contextual details. If the patients or therapists felt unable to answer any questions during the interview they were not pressed to do so.

The interviews were audio-taped with the express permission of the participants and were carried out in accordance with in-depth semi-structured interview methods. Participants were reminded that they could terminate the interview at any time if they did not wish to continue. The topic guides for the interviews were based upon key questions about the observed events of the treatment session. For the therapist interviews, the questions included: what the therapist's aims were in the treatment session and what strategies they used to achieve those plans; what power the therapists felt they had available to achieve their plans in treatment and what they perceived the patient had and could use to achieve their own plans; how easy or difficult it was to share these strategies and plans with patients and how involved the therapist felt the patients were in the events in the session. A copy of the therapist interview topic guide is in Appendix G.

In the patient interviews, the questions pursued included: what the patient felt they wanted to achieve in the treatment session and what strategies they felt they used to try to get what they wanted; what personal resources the patient felt they had available and felt able to use to achieve their plans; how easy or hard they found it to do what they did in the session; whether they discussed what they wanted and the strategies they used with the therapist and how easy or hard this was to do; whether they followed the therapist's plans or their own plans in treatment and why this was so. A copy of the patient interview guide is in Appendix G. The terminology used in the interviews was adapted as needed to meet the understanding of the participants, particularly the patients.

Additionally, other mediums such as pictures or actions were used with those patients who had expressive communication difficulties. These resources were constructed following discussion with a speech therapist who was also a postgraduate colleague and were used to aid patients' understanding of questions and to offer ways by which patients could express their views by pointing, writing or acting out what they meant. The resources were drawn freehand or constructed from internet clip art and included pictures of physiotherapists-patient treatment activities, pictures of people talking or making plans, faces with a range of expressions to indicate feelings, cards with boldly written words and sheets of blank paper and large felt pens. During the interview, the researcher made a point of stating for the tape when the patient referred to or used one of these resources. This aided in the interpretation of the patient's meaning during transcription. Copies of some of the resources used are to be found in Appendix H. At the end of the interviews, the therapists and patients were debriefed to answer any questions they had.

3.9.7.3 Data management and transcription

The data from the case studies were prepared prior to analysis to render them into an accessible format. The rough field notes from the observation schedules were written up in detail and the audio-recordings of the observation sessions and the interviews were listened to, reviewed and transcribed verbatim following generally the rules outlined in section 3.8.7. In these data the participants were identified in the transcriptions as 'therapist', 'patient', 'patient's wife', 'technician' (therapy assistant) and 'researcher'. As was done in the phase one study, this reformatting process was typically carried out shortly after the data had been collected. This was advantageous as it enabled the field notes and audio recording transcriptions to be completed more fully in conjunction with the researcher's recent memory of the events. This helped to clarify the direct transcriptions of the recordings of the treatment sessions, some of which were poorly recorded and difficult to decipher due to the movement of the participants about the treatment gym and the extraneous noise in the sessions. It also served to clarify the early interpretative meanings of the data.

3.9.8 Analysis of case studies

3.9.8.1 Within and cross-case data analysis using 'Framework' method

Once the data-sets were written up and transcribed, they were then subjected to a progressive analytical process following Ritchie & Spencer's 'Framework' method of qualitative data management and analysis (1994). This process comprised a series of steps wherein the case study data were interpreted and mapped and the explanatory theory developed within and across the cases using a progressive analytic thematic framework. With reference to Ritchie & Spencer (1994), the steps in this analytic process will now be described in more detail. Firstly the six complete case study data-sets were read individually several times by the researcher and discussed with the research team. Within this process, each of the individual cases was written up to document the obvious impressions and surface meanings of the interaction events. This early analytic process served to familiarise the researcher with the data and highlighted key themes from the data of the aims of the participants and the strategic interactions that were used by each to try to achieve those aims. These early themes were identified as: 'interaction structures' as they seemed to be structured within the treatment session and be defined in some way by the therapists' and patients' purposeful interactions in the treatment process. Four main analytic themes emerged quite early in the within-case analysis and these were called: 'negotiation of power'; 'communication interactions';

'treatment activities interactions' and 'social interactions'. From the instances of these main themes in the six case study data-sets, a thematic framework was developed which incorporated basic definitions of each theme. A copy of the within-case thematic framework at this stage in the analysis is lodged in Appendix I.

This thematic framework was then developed further by applying it to each of the data-sets in a deeper more interpretative analytical scrutiny and considering the symbolic meanings of the participant's aims and actions in relation to power which could be found underlying the themes identified in the data. This in-depth within-case analysis revealed that each of the main 'interaction structures' were underpinned by control strategies which held particular meaning for the therapists or patients as they worked together in the treatment sessions and pursued the goals that were important to them from their very different social perspectives in the institutional rehabilitation process. One example revealed at this stage was the therapist's keen control of the discussion interactions in the different treatment sessions. This seemed to be a key strategy for the therapists as it was used to negotiate control over the patient and the treatment process in pursuit of their goals. An example of how the within-case thematic framework developed in the analysis is lodged in Appendix I.

The 'strategic control negotiations', that is the strategies that therapists and patients used to negotiate control over each other in interactions as they pursued their own goals on the basis of their own experience, were first charted on a case by case basis. However, to achieve a more in-depth explanation of what these meant in terms of the therapist's and patient's individual goals and the definitions of the powers which therapists and patients could use with each other in their institutional roles in therapy it was necessary to map out the themes in a cross-case analysis. This served to develop an understanding of the higher order concepts of the 'strategic control meanings' of the therapist and patient groups. A working example of the cross-case analytic mapping process is in Appendix I. From this comprehensive analytical process, patterns of goal-directed strategic behaviours of the therapists and patients began to emerge. This in turn crystallised the theoretical models of how these behaviours interacted with each other to form the roles and powers of 'the therapist' and 'the patient' in the treatment interaction and outlined a new dynamic social model of the meaning of partnership working in the stroke therapeutic treatment interaction.

3.9.9 Secondary analysis process

The stage two study comprised six qualitative case studies from participants sourced from two research sites. However, due to considerable difficulties in recruiting patients, the study failed to achieve the desired ten case studies considered necessary to achieve a satisfactory level of theoretical explanation. Difficulties in patient recruitment continued throughout the study despite the implementation of several strategies to counteract these problems. At the beginning of the study the intention was to recruit patients at the in-patient stage just prior to their discharge to out-patient treatment. However, this proved time consuming for in-patient therapists to manage and an amendment to ethics was made to enable patients to be recruited at the out-patient stage with the assistance of their out-patient therapists. This recruitment strategy was more effective than its predecessor. However, difficulties continued as the out-patient (day hospital) services involved in the study were in a state of continuous re-development. This resulted in several changes in physiotherapy staffing and relocation of day hospital sites which put greater pressure on staff and this inevitably influenced their ability to devote time to the study's recruitment activities.

Another ethics amendment facilitated the setting up of an additional research site in an affiliated Hospital Trust and this helped to further recruitment in the study. Because of the many changes in the study's collaborators in the rehabilitation services, much effort was put into building and sustaining good working relations with the physiotherapists and managers involved in the study. This included visits to departments to discuss problems to provide understanding and support and talks about the study in staff meetings. There is no doubt that the good natured commitment of the physiotherapist collaborators to the study contributed to its final success. In reflecting upon the recruitment difficulties experienced, it is evident that the main problem was the changing nature of the institutional services involved and not the protocol or the collaboration processes. The impact of the service changes continued to constrain recruitment despite the hard working commitment of the physiotherapist collaborators to the study and efforts to simplify the recruitment protocol to facilitate better results. Overall, recruitment for the second stage study took 13 months. It is realised that difficulties in recruitment are probably inevitable when trying to conduct research in the NHS, as the priorities of the institution will often outweigh those of research. However, it must concern researchers who are trying to design ethical and practical studies within limited budgets as they may now have to speculate resources to deal with complex and unpredictable service difficulties.

The intractable nature of the recruitment difficulties experienced were a serious problem. The PhD project had no further resources of time or funding to pursue other research sites for further participants to complete sufficient case studies to achieve a satisfactory theoretical development. Following discussion within the research team, it was decided that the project could exploit its links to the research project which had been its forerunner to utilise the qualitative data therein for a secondary analysis. In this respect, it was planned that the data from the prior study would be subjected to the analytical framework of the present study to enhance the theoretical framework and to extend the development of the explanatory models of the strategic use of power and partnership speculated in the six main case studies.

Since the study by Wiles et al (2002) was grounded in the same substantial research area and had utilised similar research methods of direct observations of stroke physiotherapy treatment sessions and follow-up interviews with the therapists and patients involved, it was considered appropriate for analysis in association with the present study's methods and data. This finding accords with Coyer & Gallo (2005) who advise that the fundamental concepts being dealt with in the primary and secondary studies should be compatible to permit analytical development of the data. Before dealing with the way the secondary analysis in the present study was conducted, it would be wise to discuss more fully the theoretical rationales and ethical considerations of this rather different research process to decide why its use was justified in this work.

3.9.9.1 Rationales of secondary analysis and its justification in the present research

The secondary analysis method is defined by Hakim (1982 cited in Hinde, 1991) as an additional analysis carried out upon existing data sets in which a different interpretative explanation is achieved from the original inquiry. On the surface this might seem like a convenient strategy to use to flesh out a project which has attained a limited store of data and of which more is needed to build an in-depth explanatory theory. However, Hinde (1991) and Coyer & Gallo (2005) warn that there could be negative as well as positive implications of using data other than one's own in a research project. As Hinde and Coyer & Gallo note, one of the main objections to secondary analysis is that it could be unethical to use data from another study without the consent of the participants and the permission of the original researchers. Questions could also be raised about the use of secondary analysis in a PhD degree, which is supposed to produce an original piece of research which contributes fresh knowledge in its area of inquiry (Hinde, 1991; University of Southampton Postgraduate Degree Regulations, 2005).

It was acknowledged that the process of subjecting data from another study to further analysis for which they were not intended raised certain ethical questions. The main difficulty in the present context was the absence of express consent from the original study's participants for their data to be used for purposes other than the original analysis. In order to address these ethical questions discussions were held with the present study's supervisors who were also the senior researchers involved in the Wiles et al study. Whilst this could not substitute for the consent of the participants, it enabled an ethical rationale to be reached for the secondary study to continue without further consent from the participants being sought. This rationale was based upon the present study's existing connection with the earlier work by Wiles et al as a direct descendent. Thus, as the present research could be interpreted as an extension of the original work, it was concluded that no ethical concerns of inappropriate use of data were breached.

Addressing the second concern of the use of secondary analysis in the PhD and whether this would constitute the development of original work, it was reiterated that the secondary analysis would take a portion of the qualitative 'cases' from the Wiles et al (2002) study and develop them further using the analytical framework devised in the six case studies of the PhD project. By so doing, it was expected that new knowledge would be created which could develop the theoretical understandings of both studies to a deeper level. This would also make the theoretical link between the two studies more explicit and extend the explanatory models of the research in the substantive area with greater credibility. This general principle has some support in the literature. For example in work by Kelder (2005) which utilised secondary interview data to substantiate theories constructed from video data of the activities of weather forecasters. The analysis of secondary data can therefore be seen as adding another dimension of understanding to the developing theory and this triangulation of data sources is upheld as a methodological strength (Mays & Pope, 1995).

3.9.9.2 Selection of data for secondary analysis

The available data in the Wiles et al study were derived from eleven longitudinal case studies which had been transcribed into Word documents by the original research team. Each case study comprised two observed and audio-taped physiotherapy treatment sessions and three semi-structured interviews each with the therapists and patients involved. From this pool of data, a selection was made for inclusion in the secondary analysis process. This selectivity was structured in accordance with the research aims of the stage two study and this served to support the quality and credibility of the secondary analysis process. The secondary data were selected for use on the basis that they met the following specific criteria:

1. Observed treatment sessions which occurred in out-patient setting in day hospital gym or 'neuro-gym'.

2. Data-sets which comprised one observed treatment session audio-transcript and its accompanying field notes transcript and the two transcripts of the patient and therapist interviews which followed up the observation sessions.

3. Transcripts of data which appeared complete.

Of the eleven longitudinal case studies from the Wiles et al study, seven 'data-sets' were isolated which broadly met the above criteria. Of these seven data-sets, four were subjected to the in-depth secondary analysis process. Three of the eligible data-sets were not included in the secondary analysis process due to concerns about the completeness of the data transcripts.

3.9.9.3 Analytical methods used with secondary data

Once the secondary data had been selected, it was dealt with using exactly the same analytical methods used for the primary case studies. These methods have been documented in detail in section 3.9.8 of this chapter and as such will not be repeated here. Further critical discussion of the secondary analysis process including its positive aspects and shortcomings can be found in section 8.8 in the general discussion chapter 8.

3.9.10 Procedures to ensure the quality of the research

This research project has sought to conform to high standards of process and theoretical development as recommended in the literature in order to achieve a quality outcome (British Psychological Society, 2000-2004; Pope & Mays, 2000; Lincoln & Guba, 2002; Yin, 2003). As the research followed a social constructionist ontological approach in its examination of how social power and partnerships are constructed in the shared symbolic interactions of therapists and patients, its quality cannot be appraised using positivist standards of reliability, establishment of valid truths and generalisability of theory. In qualitative research the quality of the work can be judged on how far the researcher has ensured and demonstrated the 'credibility' of the research and its theoretical outcomes and the 'transferability' of the theory to other settings (Lincoln &

Guba, 1985; Koch, 2006). These quality standards and the way in which they were applied in the present study will be discussed next.

3.9.10.1 Credibility

Qualitative research is judged to be credible if it is shown that steps have been taken to ensure that its theoretical outcomes are meaningful in context (Lincoln & Guba, 1985; Pope & Mays, 2000; Mays & Pope, 2000; Koch, 2006). As the above authors discuss, this can be achieved by sharing the study's interpreted meanings and conclusions with the participants or corresponding individuals to invite feedback on how resonant these constructs are in the clinical context and in the experiences of those involved. In the stage one focus group study, credibility of the main themes was established by presentation of these interpretations to a focus group of therapists for discussion of their relevance in practice. Discussions of the developing theories were also held with my supervisors and postgraduate nursing and therapist colleagues. In the stage two study, credibility was established by discussing the early interpretations of the treatment session data with the participants in their follow-up interviews and by discussions of the developing within and cross-case thematic analyses with supervisors and postgraduate colleagues. The concluding models of the interaction of patient and therapist 'expertise' and the interaction influences on partnership were also discussed with a therapist group and a mixed healthcare professional group. These discussions have supported the quality of the outcomes of the thesis because they have helped to forestall the influence of my own preconceptions on the interpretations made in the analyses.

Credibility was also established in the research through triangulation (Denzin, 1989; Mason, 1996; Pope & Mays, 2000). The use of triangulation in the construction of theory is intended to facilitate as comprehensive a level of understanding of the research question as possible and this can be achieved by employing strategies which provide multiple perspectives of the social interaction being studied (Denzin, 1989; Mason, 1996; Pope & Mays, 2000). Denzin (1989) suggested that this could be achieved by triangulation of 'data sources', 'methods', 'investigators' and 'theories.' In the present context, triangulation was applied in the stage two study through the use of multiple data sources and multiple data collection methods. The multiple data sources were the six primary case study treatment sessions, the four different research sites from which the primary cases were sourced and the four secondary 'case studies' of treatment sessions from an existing archive of qualitative data. The multiple data collection methods were the observation and interview data collection tools used in the case studies.

3.9.10.2 Acknowledgement of participants as research partners

Once the data collection events were over, participants were given the opportunity to feedback on how they felt about taking part in the research. Such debriefing sessions are recommended by ethical research standards in order to ensure that participants have experienced no distress but also to enable them to ask questions and seek further information if necessary (British Psychological Society, 2000-2004). One of the points that arose frequently during such periods concerned the physiotherapists' keen interest in being informed about the study outcomes. I was able to give assurances to the therapists at the various study sites that feedback on the main conclusions would be given in seminars at the end of the project. For practical reasons it was not possible to provide such feedback to all the patients at the end of the project. However, patients were invited to contact me if at any time they felt they wished further information on the project's progress.

It is possible that with many diverse clinical and academic research projects in progress, that participant groups, particularly healthcare professionals and patients might become over researched and feel used by the research community without adequate acknowledgement and feedback. However, it is likely that participants may feel they have a stake in the study, that they are an integral part of the research, having contributed their time and experiences. Indeed, this is the case in the present research where the aim is to produce recommendations for future practice in physiotherapy. Perhaps it is a natural sequel of the interaction that takes place between participants and researcher during qualitative research that creates a sense of partnership which participants may want to maintain. In the present project, the interaction in the focus groups and the case studies may have intensified for the physiotherapists and patients the sense of being co-researchers, which in effect they are.

3.9.10.3 Reflection on my part in the studies

Mays & Pope (2000), Lincoln & Guba (2002) highlight the importance for qualitative and case study researchers to reflect upon their own influence on the process and outcomes of their work as this can uphold the credibility of the research and its theoretical outcomes. In accordance with the social constructionist and interpretative methods used in the present work I have played a contributory part in the production of the data in conjunction with my interaction with the study participants in the focus groups and the case studies (Bryman, 2001; Schwandt, 2003; Adler & Adler, 1998; Fontana & Frey, 1998). In the focus groups I was involved in the group interactions with the participants as I carried out the role of moderator by which I managed the group discussions to ensure that these were fruitful and covered the topics I wished to explore. In the case studies, I interacted with the participants as I observed their activities in the treatment sessions and when I conducted in-depth face to face interviews with each of the therapists and patients involved. I have also reconstructed and interpreted the data from the studies through the processes of my analytical thinking, my writing and discussions with my supervisors and therapist advisory groups in order to test out the credibility of my interpretations.

My engagement with the participants, the data and the interpretative analysis has been predicated upon my professional and academic knowledge and experience. I am a registered nurse by profession with experience in the fields of orthopaedics, general medicine and clinical research. This has included some experience in nursing stroke patients and in working with physiotherapy staff in patient rehabilitation and this enabled me to establish good working relations and communications with these groups of participants in the research process. My experiences as a nurse working in the NHS and with physiotherapists as a fellow healthcare professional have provoked some changes in my reflections over the period of the research. At the start of the project my understanding of the practice, professionalism and social power dynamics of physiotherapists was quite limited, despite my prior experience of interacting with physiotherapists as they worked with patients on the wards. This is most likely because the focus of my attention in my clinical practice at that time would have been my own professional responsibilities and duty of care towards the patient. I would not have been observing as a social researcher and probably would not have interpreted the communication interaction of therapy treatment as a dynamic of social power negotiation.

As the research has progressed and I have engaged more closely with physiotherapists, their practice, their interactions with patients and the perspectives of patients receiving treatment, I have developed a deeper understanding of the complex social nature of physiotherapy and the therapist role and how this influences patient-hood. This understanding has over the course of the project led me to reflect upon the social power dynamics of my own practice and the professional power of the nursing role and its impact upon patients and their participatory role in treatment.

In addition to the clinical data collection skills gained as a research nurse, I possess a BSc in Psychology. This prior experience in conducting qualitative interviews and in managing participant recruitment activities assisted my engagement of these activities during the PhD. In view of my prior experience it has been important whilst conducting the analysis of the two studies to be aware that I might be imposing my own interpretations on the data and that these might have differed from the intended meaning of the participants. As discussed in sections 3.8.8.3 and 3.9.10.2, it has therefore been important to discuss my interpretations of the data with therapists groups, with the case study participants during the course of their interviews and with my supervisors, one of whom is a physiotherapist herself.

As a student project, the study sought to conform to the rigorous standards of research practice and thus, attention was paid to my training needs to ensure that I possessed the skills necessary to carry out the research successfully. In many respects this has involved learning to use different research methods in the context of conducting the study itself and so it has been important for me to maintain an awareness of how this may have affected the study at each stage. Discussion of the study with supervisors and academic colleagues has facilitated this awareness and provided valuable feedback on the process and my role. Writing up the project has also facilitated reflection at all stages in the research process.

3.9.10.4 Transferability of the research

It was not intended that the participant samples in either of the studies would be representative of physiotherapist groups or physiotherapist-patient dyads at large. Rather the purposive sampling strategy was used to facilitate the development of the theoretical understanding of the research topic (Silverman, 2000). In this respect, the research may in a literal sense be grounded in the peculiarities of a local phenomenon. This raises the question of the interest and relevance of the theory developed in the study to a wider audience. Qualitative researchers attest that such theoretical developments cannot be generalised to other conditions or settings (Lincoln & Guba, 1985; Mason, 1996; Silverman, 2000; Koch, 2006). Instead, they uphold that qualitative theories are 'transferable', that is the detailed insights they provide of social phenomena in particular settings can be used to guide enquiries into similar phenomena in different contexts (Lincoln & Guba, 1985; Mason, 1996; Silverman, 2000; Koch, 2006). Lincoln & Guba (2002) refer to this educative process in case study reports as an 'empowerment criteria'. To achieve this, the study clearly must be disseminated to a wider audience via local seminars, journal publications and conference presentations in order that others working in similar clinical or research contexts may have the opportunity to consider the present study with reference to their own environments, experiences and research.

Exposure of the project to wider academic and clinical audiences may also serve to advance the rigour of the research as it will be exposed to critical appraisal by others, who may possess their own opinions and experiences of the research questions. In this respect, the work may continue to grow in significance as feedback is received from others on the findings, the methodologies used and the problems experienced in carrying out the research. Thus, the project must stand as a testimony to one particular research group's approach to understanding a complex and difficult phenomenon in the field of stroke physiotherapy practice.

Chapter 4 Results of stage one study

4.1 Introduction

This chapter presents the results of the stage one focus group study which was carried out with physiotherapists. Details of the demographic data will be presented first then the main results of the study will be dealt with. The results will include excerpts from the focus group transcripts with discussion of the meaning of these data.

4.2 Participant demographics

Six focus groups were completed as part of the data collection process. One further group was conducted at the end of this period in order to validate the interpretation of the data and the developing theory as part of the analysis process. Participant numbers and physiotherapist grades for the seven focus groups conducted are summarised in Table 1. In total thirty-four physiotherapists took part in the study, each attending one focus group. All the physiotherapists were female. Ethnic origin and age of participants were not recorded. Thirteen Senior I and fifteen Senior II graded physiotherapists took part in the first six focus groups and three Senior I and two Senior II grades and one superintendent physiotherapist took part in the validation focus group. The range of participants' area of clinical practice covered acute, in-patient rehabilitation and out-patient rehabilitation services. All of the physiotherapists worked with stroke patients, some exclusively and others with a range of neurological conditions.

Table 1. Summary of participant numbers and physiotherapist grades

Focus Group	**Participant Numbers**	**Senior I Grades**	**Senior II Grades**	**Superintendent Grades**
PT 1	7	3	4	-
PT 2	7	6	1	-
PT 3	4	1	3	-
PT 4	3	2	1	-
PT 5	2	-	2	-
PT 6	5	3	2	-
PT 7 (validation)	6	2	3	1
Totals	34	17	16	1

4.2.1 Comments on the effects of group sizes and group relations

As noted in the previous section the numbers of participants in the seven focus groups ranged from two to seven. This outcome was contrary to the plans of the study which were to have between five and ten participants in each focus group in order to facilitate satisfactory group interaction and discussion. The smaller group sizes of two and three were found to have some effect upon the group interaction. The participants in these groups appeared a little self-conscious at first and in the early stages the discussion was somewhat restrained. However, as the groups progressed, satisfactory discussions of the research topics developed and this may have been because the therapists were all professionally acquainted with each other as colleagues working in the same hospital Trust. The groups with two participants demonstrated no hierarchical tendencies, however in all of the other groups at least one participant appeared to take the lead and dominate the discussion. This was successfully managed by directing questions to quieter group members to encourage them to enter the discussion and to offer their views. All of the participants contributed to the discussions in some degree.

4.3 Study findings

Thematic analysis of the physiotherapist focus group discussions revealed two broad themes which were considered core themes: 1. Barriers to shared communication in stroke physiotherapy treatment; 2. Interventions to support shared communication of stroke physiotherapy treatment. Further analysis of these core themes developed more interpretative second-level or sub-themes. All of the themes identified are presented in Table 2.

Table 2. Core themes and sub-themes identified in physiotherapist data

Core Theme 1.	**Sub-themes of Core Theme 1.**
Barriers to shared communication in stroke physiotherapy treatment	1. Patients' perceptions of stroke event 2. Patients' inexperience of treatment processes 3. Problems explaining stroke physiotherapy treatment 4. Patients' choices of participation in physiotherapy
Core Theme 2.	**Sub-themes of Core Theme 2.**
Interventions to support shared communication of stroke physiotherapy treatment	1. Strategies to improve shared understanding 2. Strategies for empowerment and partnership 3. Instruments to support shared communication

The core themes and sub-themes identified in the six focus groups were discussed with physiotherapists in a subsequent focus group setting in order to assess the researcher's interpretation of the data in this form. The group acknowledged the sub-themes identified by providing similar examples and suggestions from their own experience as well as some new perspectives on these issues. The group also confirmed a suggestion that had been made in some of the earlier focus groups that it was important to highlight the distinction between the acute and out-patient rehabilitation stages when considering the problems of shared participation in treatment and what might encourage and facilitate this. As the group confirmed, this is because the problems and situations are often very different in the two stages and the appropriateness of any support strategies must recognise this distinction too. Where distinctions of the treatment stage have been made in the data, this has been highlighted. Each of the core themes will be presented in discussion of their interpretative sub-themes along with illustrative examples referenced from the data as appropriate.

4.4 Key to data examples presented

The individual focus groups are identified by the label 'FG PT' and a number from 1 to 6. The illustrative examples quoted in parenthesis have not been attributed to individual participants due to problems experienced in separating different participants' voices on the focus group tapes during transcription. This also prevented the identification and following through of consecutive comments made in the data. Short series' of dotted lines in the text (....) have been used to illustrate sections of missing data or pauses in the participant's comments. Missing data are defined as segments on the tapes which cannot be transcribed due to poor quality recording or segments of text which have been removed from transcript excerpts because they are interpreted as not being relevant to the theme in question. Examples that begin with a small-case letter and those not finished with a full stop indicate that the excerpt taken is not the complete sentence.

4.5 Detailed description of core and sub-themes

4.5.1 Core theme 1.: Barriers to shared communication in stroke physiotherapy treatment

4.5.1.1 Sub-theme 1. Patients' perception of the stroke event

The physiotherapists indicated that one of the early problems they faced in communicating with patients about plans for treatment after stroke was that patients often had little or no insight into what had happened to them or an understanding of what stroke actually was. This was a problem for the physiotherapists as they tried to work with patients in assessing their problems in the process of planning treatment as it appeared that patients were sometimes unable to recognise how the stroke had affected them. This is illustrated in the following example from the data which suggests the physiotherapist's frustration with the patient's inability to see and understand what is wrong with them.

FG PT 2 *"sometimes you can say to the patient have you...what are your problems? What are your main problems and they'll say they haven't got any and yet they're not moving the right side of their body."*

The physiotherapists went on to emphasise that the patient's lack of awareness of what had happened to them may be considered a symptom of the confusion and shock that patients typically experience in the acute period shortly after stroke. It was also made clear that the patient's ability to comprehend and deal with the stroke and to take in information offered by those caring for them might also be severely affected by any cognitive impairments occurring as a result of the stroke. It was suggested that it might take some time for these problems to resolve and for the patient to begin to appreciate the significance of what had taken place. As a result, it was recognised that patients' ability to consider and to share their thoughts and plans for recovery with the therapist would also be restricted in the acute period after stroke.

FG PT 1 *"the fact that it's just happened to them that there is still...is a shock that the stroke has just occurred they're not quite sure whether they're coming or going at that point and the time aspect for them to get used to their condition, what they can or can't do and then what they want to be able to achieve."*

FG PT 3 *"The patients we see are very acute, very unwell, often unresponsive or lower conscious level so that's one of the aspects we're dealing with is that the patients are not often comprehending sort of... implications or what you're actually telling to them"*

Aside from the impact of the stroke on the patient's comprehension and cognition abilities, it is possible that patients may simply not perceive that what has happened to them is a problem. The physiotherapists asserted that patients might rationalise what had happened to them and its consequences by considering what they thought had happened to other people after stroke. In this respect, physiotherapists might be working with patients who had found their own way of understanding the stroke event and what its outcome might be. However, it was also made clear that the patient's picture of events often presented problems for the physiotherapists as they tried to discuss the realities of the outcome of the patient's stroke with them.

FG PT 3 *"I've found in the past they will often compare what is happening to them to someone, a neighbour, friend or someone that has had a similar thing happen to them before, when actually it's completely different what they've had....and often they'll say, oh, I know Mrs so and so and she got up and walked within 5 days, you know, and* *like…Trying to get through to them that yes, they may have done, but that yours is different"*

4.5.1.2 Sub-theme 2. Patients' inexperience of treatment processes

Patients' lack of knowledge and understanding about goals and treatment and their inexperience of dealing with these processes were issues that came across frequently in physiotherapists' comments about the difficulties they had in trying to plan goals and treatment with patients. The physiotherapists emphasised that patients' lack of awareness and understanding of the concepts of goal-setting were often more marked in the very acute stages after stroke. In this period, the therapists said they accepted the fact that patients' physical and mental frailty could make it difficult for them to remember things or to concentrate on making plans other than surviving and feeling better. At this stage in treatment, it seemed to be understood that sharing or discussing plans with patients was usually extremely difficult. The difficulties might also be increased if the patient had existing hearing problems or was very low in mood after the stroke. Most of the physiotherapists stated that they tended to try to involve the patient's relatives in the very acute stages to discuss early plans for treatment.

FG PT 3 *"I think it's very difficult em...when they're very, very acute, they're not even thinking that way because they're so unwell. They really, the only thing they do is laying in bed and at that stage you don't even know if the patient's going to survive or not...So you're actually not going to start talking about going home and...and them going back to work and everything in that stage"*

FG PT 2 *"And cognitively they can be so reduced in... terms of what they can actually really comprehend what you're trying to work towards... you've gotta work with them and relatives as well"*

Moreover, it was acknowledged that many of the acute stage treatments, such as chest care, focussed on goals that would probably not be noted by patients. At that level it seemed that the therapists tended not to discuss treatment with patients, although they acknowledged that they would still try to tell patients what they were doing as they were treating them. The physiotherapists also noted that patients often simply did not understand the concept of using goals to plan for achievements in rehabilitation. Indeed, it was suggested that it was unrealistic to expect patients to deal with new concepts such as goals in the early stages of their stroke because of this.

FG PT 1 *"it's quite hard for them to actually come into a hospital and suddenly have to think about goals and what they want to achieve. It's all too new and fresh. So it's not something I do in the first week. I usually just get to know and chat to them generally."*

From this excerpt it is noted that physiotherapists advised deferment of formal discussion of goals and treatment for a period of time. However, it seemed that physiotherapists' difficulties in goal-setting with patients did not get any easier, even when patients were more able to consider what they wanted to do. The problem appeared to be that in considering their own plans for achievement, patients often focused upon complete recovery from stroke. The physiotherapists, with their greater experience of stroke and its outcome understood that this was probably an unrealistic expectation for patients. However, the physiotherapists stated that they felt unable to give any clear prediction of recovery to patients and that they preferred to plan shorter-term goals to enable assessment of the patient's progress in short steps. The following quotations from the data illustrate some of the problems encountered.

FG PT 1 *"I don't give them any prognosis at that point at all. Usually, I don't think anybody would try and give them any sort of idea of whether they're going to make a full recovery or not especially in the early stages"*

FG PT 1 *"I suppose the difficulty we have is for them to be realistic because their goals are not going to be achievable at least in the short term and it's quite difficult to focus them down into em...achievable short-term goals."*

FG PT 2 *"I think patients make it harder to look in the short term rather than just they...they tend to just look at their...their ultimate outcome rather than actually breaking it down like we would do."*

However, even without any clear information about recovery – or perhaps because of a lack of any clear guidelines – the patient's persistent expectation of complete recovery often persisted. It was suggested by the physiotherapists that this might be due to patients' faith in physiotherapy as a curative treatment for stroke. It was also suggested that it was difficult to get patients to lose this sense of hope and expectation in their present predicament. Physiotherapists noted that this expectation might also be fostered by others – medical staff for example – who might speak of physiotherapy to patients in terms of its success in dealing with stroke. Because of this any attempts to discuss goals and plans for recovery with patients often led patients back to their ultimate goal of being able to walk, go home and return to pre-stroke life, despite what the physiotherapists told them. The following examples from the data illustrate this.

FG PT 4 *"I think they think that they get their physio, they have to work hard for a few months and then absolutely everything will be fine"*

FG PT 2 *"you've got someone that goes yeh...yeh...get it all and then 6 months later even they're asking why aren't I walking when you said I would walk and yet you'd explained actually we weren't ever aiming for you to walk. They almost set their goal and it's very hard unless you're constantly reiterating you know, this isn't a very realistic expectation at this time"*

FG PT 5 *"you can talk till you're blue in the face about exactly where they are now, but they're just not going to take it on board. They want to be back to where they were before."*

The physiotherapists noted that in the later stages of treatment, patients might have difficulty in recognising and understanding the more complex and specific goals of treatment. These goals might include balance maintenance or arm and shoulder work which the physiotherapists might be concentrating on to achieve better quality of movement. Thus, it was felt that patients might not appreciate the progress that was being made in the same way that the physiotherapists understood it. In this respect, it was unlikely that patients would understand treatment as being anything other than progress towards walking again.

FG PT 5 *"It gets more difficult when it's more specific...and they get further along and your improvements are small...and you're talking about how the position of their arm and stuff like that. They can't always see it so they don't know they're achieving."*

FG PT 3 *"In my experience, most people if they think they're on their feet, they're ready to go home. So, it's only when they can see that there's other things that need doing first, that they'll accept it. But most people's goal is to walk."*

4.5.1.3 Sub-theme 3. Problems explaining stroke physiotherapy treatment

Physiotherapy was presented as a complex form of treatment and the physiotherapists expressed concern that their patients might not have any awareness of what was being done in treatment and how this was being carried out. One of the reasons offered by the therapists for the patient's lack of understanding was that physiotherapy was often carried out and communicated through the medium of touch. In this process, the physiotherapists explained, they assessed patients' muscle tone and directed their movements using their hands with little verbal interaction at all. The suggestion was that this tactile process and its messages may not be so apparent to patients.

FG PT 4 *"It's quite difficult to say oh we do this and we do that, because it's not really like that and I think a lot of the communication isn't always spoken as well and em...they kind of get the general gist of what you're doing, but I don't think they always do understand."*

The physiotherapists said they found it hard to express what they were doing when they were treating patients. They said it was hard to try to translate their plans for treatment to patients because they had to translate the tactile and physical processes of therapy into words whilst trying to verbalise their rationales for the treatment that was being carried out. Moreover, this had to be done in language appropriate to the patient's level of understanding, avoiding the use of jargon.

FG PT 4 *"And when you're looking at walking then they'll say am I walking sort of...right or normal, so your goals will be working on perfecting that, but the way you do it may be difficult to translate to them."*

FG PT 1 *" and it's very difficult for us.... to actually translate what we're thinking what we're saying to get that message across."*

FG PT 1 *"We obviously use a lot of jargon"*

4.5.1.4 Sub-theme 4. Patients' choices of participation in physiotherapy

The influence of stroke related cognitive deficits and age-related hearing problems on the patient's ability to take part in the plans of treatment have been discussed already. However, other factors were noted by the physiotherapists as affecting the patient's involvement in treatment. Most of these factors related to the patient's own choice of whether to participate or not and this choice itself was influenced by different factors in the patient's experience of healthcare, their understanding of what was expected of them in treatment and more fundamentally, their personal feelings.

The physiotherapists raised concerns that sometimes patients seemed to make firm decisions not to take part in treatment. This choice for non-involvement was seen sometimes as the patient adopted a passive role in the process, perhaps as a result of feelings of hopelessness and depression or an inability to accept the reality of the stroke event. It could also arise from the patient's belief that they were supposed to submit to the ministrations of the physiotherapist whom they expected to be the experienced leader in the treatment process. This expectation of being the passive recipient of care and treatment could have been built on the basis of previous experience of therapy. The following three examples from the data illustrate these problems well:

FG PT 3 *"I don't feel my patients have much involvement in the early stages. The early stages, I think patients are quite happy to be guided."*

FG PT 1 *"and so, when you're trying to talk to them about em...what they're likely to achieve they're... looking to you for a lead em...then they'll often em...say you're the expert you tell me what I'm going to do"*

FG PT 3 *"And also emotionally, how they are, if they're depressed and not wanting maybe to join in with the physio and trying to ignore it and you know, they're very passive"*

Alternatively, the physiotherapists suggested that patients' decisions could be based on a preference not to undertake rehabilitation because they were elderly and felt they could not keep going. Patients could also feel that they were unable to accept the stroke at that time or were undergoing what the physiotherapists perceived to be a 'grieving process' about what had happened to them. It was also possible, said the physiotherapists that patients may simply be making a choice not to go any further with treatment at that time.

FG PT 4 *"I think occasionally, though, you get patients like that who say that obviously, they haven't got any cognitive impairments and they're very clear that I know that X, Y and Z would be involved if I'm gonna go for the rehab process, but I don't want to put that in, I'm happy where I am."*

The physiotherapists observed one particular difficulty that arose as a result of the patient's inability or unwillingness to be active in managing their treatment and this involved carrying over the plans of treatment to other members of the rehabilitation team. The physiotherapists seemed to be warning that the patient's inability to understand or communicate their progress and capabilities to others involved in their care might result in their rehabilitation being compromised.

FG PT 2 *"But then we're only there for two sessions a week and trying...you know, we get the patient rolling by themselves and then for the rest of the week the patient for...you know, for them, they're doing it all and the patient, you know, sometimes they* *just haven't got the ability to say [to other staff] I can actually do this for myself and the understanding's just...the kind of whole rehab ethos is just not there and it's very difficult to get them [patients] to take on that kind of role."*

Whatever the patient's reasons for persisting with their decision not to take part, the physiotherapists recognised that it would have serious implications for their treatment and recovery and present problems for the progress of rehabilitation.

FG PT 4 *"And it's gonna affect your rehab, because if they don't wanna do anything, they're not gonna join in."*

4.5.2 Core theme 2.: Interventions to support shared communication of stroke physiotherapy treatment

4.5.2.1 Sub-theme 1. Strategies to improve shared understanding in treatment

Three areas were identified in the data which referred to how physiotherapists could improve shared understanding and communication of treatment with their patients. These concerned strategies that the physiotherapists considered might help the patient to develop a clearer insight into what had happened to them and what was going on in treatment, what might support shared understanding and discussion of goals for achievement and what might support shared discussion of plans for recovery.

In the first instance, it was considered that once the physiotherapist felt the patient was able to understand, they should be given very basic facts about their stroke. The physiotherapists suggested that it was important for the patient to be kept fully informed of what was taking place in therapy and about their progress. However, they also stressed that this should be carried out in a sensitive manner to ensure that the patient should understand the information given. It was suggested that the physiotherapist should consider assessing the patient's comprehension ability – perhaps in association with the speech therapist – to identify the appropriate level of communication for the patient and to adapt the information accordingly. It was noted as important that the physiotherapists communicate with the patient in plain language and to be consistent in what they said.

FG PT 2 *"I think it very much depends on the assessment. I think you have to tailor what you're saying going on the assessment, their cognitive ability and their level of understanding of what's happened to them."*

Timing of information provision was raised as an important point as information given too early might not be taken in or might not be understood by the patient. Thus, a later stage of treatment may be more appropriate.

FG PT 4 *"I think sometimes in the very early stages, if they're very confused and agitated, I try to give the information probably too early because it just agitates them further or distresses them further em...I think I could say further down the line they've em...got a more realistic [out] look sometimes"*

However, it was also recommended that the physiotherapist should actively discuss things with the patient, at intervals and repeat things if necessary. This would show them their present situation in stroke and help them understand the therapist's role in their treatment. This would be relevant for patient's relatives also, particularly if they were elderly.

FG PT 6 *"I mean the majority of the customers are elderly population, the majority of the carers are elderly as well. It's as traumatic for them as it is for the patient and you...you know that you're going to have to repeat things."*

The physiotherapists asserted that patients may not achieve proper insight and understanding of their situation until some time after the stroke event and often not until after they had gone home and had time to come to terms with what had happened. The implication was that therapy should not be considered as being given wholly in the first few months after stroke but that patients should be allowed to go through rehabilitation in their own time and be able to return to treatment at a later stage – sometimes two or three years after the stroke itself.

FG PT 4 *"I think that sometimes the ones that do well, maybe a year, two years, three years or whatever, down the line are sometimes the ones that have almost gone home, realised that and I think almost gone through a grieving process, and then come out and said right, I'm ready now to do my rehab."*

In the second instance, recommendations were offered on sharing and establishing goals with patients and how to discuss plans to achieve these goals to ensure that this was done with mutual understanding and intent. Physiotherapists' suggestions in this area linked quite closely with concerns about communicating at the level of the patient's comprehension. It was stressed that the patient's physical problems and both the therapist's and the patient's goals were discussed with the patient and their relatives as part of the treatment plan and that goals were kept simple and limited to help the patient understand. It was noted that patients might need some support and prompting to express their wishes and plans however.

FG PT 2 *"We sit down with them after we've assessed them and normally with a relative as well and go through what we've assessed and how we work really so the stages that will take them through when we goal set with them so they have quite a lot of input into how they want to progress and what they want to achieve."*

Simplification of goals and the goal-setting process was recognised as important to help the patient to understand what was happening in treatment. This might also have helped patients to understand why there were discrepancies between the physiotherapist's aims in treatment and their own. In this respect, it was suggested that physiotherapists should take the longer-term goals that the patient expressed and break them down into meaningful short-term steps to help the patient see what they needed to do to achieve their own goal. This seemed to be recommended as a way to inform patients of their progress in treatment and to motivate them also.

FG PT 2 *"I think they're more accepting though as well once you've broken things down for them they can...patients that I've had seem to understand a lot more than what...why we're doing work on sitting when they want to walk"*

FG PT 4 *"And then sometimes, once you've done it a few times, get them to break it down into smaller goals and then once they achieve them, I think they may realise they're taking a step further and it's easier then to ...to keep going with them."*

One of the physiotherapists suggested that utilising a bargaining strategy when talking with patients about what was to be done in treatment might help patients to understand its more specialised aspects and aims. It was suggested that the physiotherapist might advise the patient that if he or she managed a period of time on some specific activity, then they would do a little of what the patient wanted to do at the end, for example walking. Interestingly, it was also suggested that such a strategy might increase the patient's compliance with the physiotherapist's plans. However, whilst on the surface it appeared that the physiotherapist was suggesting a strategy to develop the patient's perception of the more specialised aims in physiotherapy treatment, the aim may also have been to increase the professional's control in the session.

FG PT 2 *"It's the case of, right, well we'll spend 30 minutes on the plinth going through things to try and activate specific muscles and at the end, a 5 minute walking* *session and that can sometimes get increased compliance and increased understanding that this is what we're eventually aiming for"*

Other strategies to help the patient appreciate the relevance of the goals of treatment were that the therapist should make an effort to relate the goals to meaningful, functional activities – hobbies perhaps – that the patient would recognise and be interested in pursuing. This was particularly stressed with reference to the physiotherapist's more specialised movement related goals which may not have been recognised or understood by the patient.

FG PT 3 *"If the patients say oh I want to walk now and he hasn't been even standing up or taking any weight on the legs, you...you can explain to him by saying okay, for walking, you first have to be able to see if you can stand, if you can use your leg and they often do understand it if you sort of bring it in that way"*

FG PT 2 *"I think fairly early on as well you em... think what is the patient's em...what are they saying their main objective is and so you've got to focus treatment around that but bring out that you'll be going for functional as well as more specific em...normal movement hopefully from a physio point of view. So it's not only what they can do but how they do it"*

The third instance involved the process of discussing the patient's progress and prognosis for treatment outcome. The physiotherapists acknowledged that this was difficult to do. The therapists suggested strategies that might be used to deal with this. The first suggested being very honest with the patient about the poorer level of recovery that was likely considering their disabilities.

FG PT 6 *"you have to be quite...not blunt but just quite firm with people and...and point out their disabilities to them so they can understand that you know, for them, going home to live on their own again isn't gonna be... isn't gonna be feasible. I think it's mean to give patients like that too much hope because if they're not going to achieve it"*

The second suggestion was letting the patient know of the uncertain nature of stroke recovery using rather vague statements recommending that everyone should wait to see what will happen. Certainly, there was some confidence that the physiotherapist would have a better chance of predicting the patient's outcome later in rehabilitation as the patient progressed and the therapist became more aware of their abilities.

FG PT 3 *"and I think, from my experience, again is...is really that the main answer you give if they ask, we don't know. We have to wait and see what time will tell us and that is very difficult, but that is often the only answer we can actually give."*

FG PT 3 *"But also, yeh, knowing how far they're going to progress afterwards, you know, I mean, further on down the line, then you have more of an idea of, when you've worked with that patient, how much they might potentially get back. Can't say for definite though"*

Some suggested that it was important for the therapist not to be absolutely negative about the patient's outcome because the factors of hope and motivation along with supportive family could contribute to their recovery. However, in more practical terms, it was suggested that the physiotherapist should help the patient to focus on fresh goals and other ways to achieve them to give patients plans to work for.

FG PT 6 *"I think it's important not to destroy somebody's hope and that... that you consider foc...sort of refocus them to ..to sort of achieve things in a different way or em...have different things em...things to work towards."*

In this respect, the process of goals – particularly short-term goals – was seen as a useful strategy to deal with the uncertainty of recovery. It was also stressed that such changes in the focus of treatment from a long-term to a shorter-term goal might not be understood by the relative for example and this reintroduced the issue of how the physiotherapist communicated their plans and actions in treatment – in this case with the family. Whichever way the subject of recovery was approached, it was felt to be very important to be clear and explicit as to the meaning of what was said to the patient regarding their recovery to avoid misinterpretation. It was suggested that words such as 'better' should be avoided and that the therapist should remember that the patient might interpret such statements differently from the physiotherapist. Thus, patients might understand 'better' to mean full recovery whilst the physiotherapist might mean a much smaller achievement.

FG PT 2 *"Some words can be quite ambiguous as well, like better, you know, we....all know we all say it and then it'll only be when you have a patient who'll come back and say well you said it would be better and they're idea of better is obviously being able to walk without a stick for example, and ours is the fact that they're actually walking even* *if it's with a stick. So, it's...I think it's ...think it's getting it said clear that the patient really understands on the same wavelength as you do."*

4.5.2.2 Sub-theme 2. Strategies for empowerment and partnership

Discussion of how to encourage patients to become more active in the plans of treatment involved suggestions of what might empower them – or make them feel able - to take on the role of 'partner' in rehabilitation. The physiotherapists suggested that this might involve them recognising the patient's expertise in the subject of stroke from their perspective as a sufferer. In this respect, it was important for the physiotherapist to listen to the patient's point of view and to acknowledge that the patient had the right to their own choices, regardless of what these were. It was asserted that the patient needed to recognise that they had a responsible role to fulfil as a member of the rehabilitation team and that it was important for them to see that the physiotherapist would work with them in therapy and not simply do things to them. Two key excerpts illustrate these points:

FG PT 1 *"I guess it's that we all say that we're all part of their multidisciplinary team that involves the patient but the patient's got to feel that they're actually a team member as well and that we're working with them and that we're not doing things to them."*

FG PT 1 *"and it's getting them into the idea that it's not...physio supposed to be done to them it's something they participate in."*

However, it was acknowledged that the physiotherapist might have to encourage this, perhaps by facilitating the patient's involvement in discussions about their treatment. In this way, the physiotherapist could provide an appropriate environment wherein the patient might feel able to ask questions and even control the level of the discussion themselves to make it easier to understand.

FG PT 1 *"also allowing the patient to ask questions as well so hopefully getting an atmosphere where you're not passing information on to them you're having a discussion with them about what's wrong with them allowing them to have the right to say I don't know what that means or slow down, you're going too quickly"*

Another suggestion was that involving the patient in setting goals and negotiating goals helped them to take a responsible role in treatment although it was noted that the patient would probably need to be guided through this process. It was also noted that the patient's ability to do this may be enhanced in the later stages of their rehabilitation as they became more aware. Negotiation appeared to be recommended as a tool to aid discussion of specific goals with patients and to make it clearer how goals should be managed as treatment progressed and plans needed to be changed. Two examples from the data describe these points in more detail:

FG PT 4 *"further down the line they've em...got a more realistic look sometimes and feeling of. ..of...of what they can and can't do. You can negotiate goals and do it together"*

FG PT 4 *"if that's what you want to do, that can be your goal and we can work on that together, but it needs adjusting to make it more realistic, or, you know, for other reasons you might well really, we've tried that. That's not working em... and maybe, what would you think about us working on this instead or... because it's negotiating really."*

4.5.2.3 Sub-theme 3. Instruments to support shared communication in treatment

In speculating upon strategies that might facilitate shared treatment plans in stroke physiotherapy, the physiotherapists discussed their use of various instruments in the clinical setting which appeared to support shared insight and communication between themselves and the patients during treatment. Achieving a level of shared understanding might encourage the patient to become more involved and encourage both therapist and patient to work more closely together in treatment. Some of these practical tools might be adapted or combined in some form to help support shared plans in treatment.
The physiotherapists suggested that some form of written contract between the therapist and the patient might be useful to facilitate clearer understanding of each participant's expected role in the therapeutic process. But it was noted that this was only appropriate for patients who were alert and able to understand what they were agreeing to.

FG PT 2 *"What we'll sometimes do, if you've got someone who's actually obviously quite cognitively alert, is almost get a contract between you when you're doing the goal-setting and obviously you're not both signing it as such at the end, it's obviously not a legal document, but that understanding of right, this is my part, this is your part and say that from the onset"*

In terms of meeting the patient's information needs, activity diaries were proposed and physiotherapists noted that these were successfully used in some rehabilitation departments. These were typically located at the patient's bedside and the patient and their family were encouraged to use these to read what the health professionals had documented regarding care. Other diary systems were suggested that the patient and carer could write in to record thoughts and activities to communicate to the rehabilitation team. However, the physiotherapists also felt that this type of instrument would not be appropriate to use in the more acute stage of stroke care where the emphasis was less on activity but more specific to stabilising the patient's physical condition.

FG PT 3 *"Seen it work down in the em..rehab environment, they've got diaries, activity diaries that are on the end of their beds, so anything they've done that day, which relatives can read and things, so that they know what people have been doing. But I don't see it working in the acute environment... Em I don't see an activity system like that working here but definitely it would work in a rehab environment because it's more ...it's more focussed on getting them doing functional activity then."*

It was thought that some patients might benefit from more specific information about stroke in the form of clear facts and research findings and reference was made to the information leaflets available on the wards from sources such as the Stroke Association. However, other therapists raised concerns that patients and carers might need guidance when information was provided to prevent misinterpretation and worry over facts on recovery or mortality for example. Moreover, one physiotherapist raised concerns that older patients and their carers may not understand that they were authorised to look at and use information sources such as activity diaries and bedside notes.

FG PT 1 *"It's a generation thing as well isn't it in the fact that they may ...that the diaries may well still be perceived as medical notes and you don't look at medical notes."*

The physiotherapists suggested a strategy that was already in operation in specialised stroke units and that they felt was more effective. This was in the form of a stroke liaison specialist. This individual, often a nurse, helped to facilitate communication between patient, carer and the physiotherapist about treatment and provided consistent information and support to the patient and carer throughout their hospital stay. It was also noted that they would sometimes follow the patient up in the community after discharge.

FG PT 3 *"And it's very good, I feel, if there's one specific key person who can actually be there to get all the questions and the system we have is that every person who comes in with a bleed will actually be seen by this nurse and she will follow them through whilst they're here and then follow them out in other regions wherever they go to and* *she will introduce these different professions as - you will see the physio and this is what they will do"*

The physiotherapists proposed the concept of an intervention that might help patients to reflect upon their physical condition and might help them see the progress that was made in physiotherapy treatment over time. This was highlighted as being a particularly difficult thing for patients to do because of their lack of experience and knowledge of stroke and physiotherapy treatment. Two interventions were suggested. The first intervention was a written review of the patient's present situation and their progress to date, documenting their basic functional achievements over the previous few days. It was proposed that the physiotherapist could construct this as required for the patient to retain. This could also incorporate a more formal statement of the goals that had been discussed and the plans of how these were to be achieved in treatment. Thus:

FG PT 2 *"What I would actually do is that we've got a form and we will probably say right this is your main problems and say well this is the treatment intervention and these are the goals that we will set together em... but that almost could be on a separate sheet, so that the patient is aware that I've identified what's wrong, what the treatment is and what are the goals that we're doing together and they can look at that"*

The second suggestion arose from the physiotherapists' claim that they sometimes used video cameras to tape patients' activities in treatment. Indeed, this might have been what one physiotherapist was thinking of when she proposed that some sort of 'reflective tool' could be useful to help patients become more aware of their present physical problems and if referred to at a later date, their progress over time.

FG PT 4 *"You can video them and then treat them for a few weeks then video them again and then show them the video and so you can say look this is what...how you were walking before and this is how you're walking now"*

This kind of strategy was indicated for use in an out-patient department, when the patient's physical appearance might have improved to the extent that they would not be shocked or depressed by their recorded image. At the acute stage, patients might be upset by their frail and dependent appearance. However, it was noted that some patients might not want such a graphic picture of themselves. The physiotherapists also raised some concerns over the appropriateness of videos with patients who might have cognitive difficulties as the patient would have to provide their consent to the films or pictures being taken. Another objection was that the videos might be time consuming to manage in the clinical setting. However, there is no doubt that some sort of visual instrument was appreciated by the patients who, the therapists said, often wanted to retain the video films to take home.

FG PT 4 *"I've videod hand function before and then treated and videod again, and ...or I've showed them and then...oh, I didn't realise I looked like that or...you know, it's quite nice for them and I think that way...I will...sometimes they're quite shocked and sometimes they're like oh, that's better than I thought."*

4.6 Critical discussion of findings

The study identified two main themes from the data: 'Barriers to shared communication in stroke physiotherapy treatment' and 'Interventions to support shared communication of stroke physiotherapy treatment'. The sub-themes developed from the first of these main themes indicated that one of the central problems preventing shared communication in treatment was that patients and physiotherapists conceive stroke and physiotherapy treatment in very different ways. Moreover, the discrepancy between their respective understandings and expressions of the realities of stroke and treatment appeared to be quite large. The physiotherapists perceived that patients often had no idea of what had happened to them in stroke and no concept of what was expected of them in treatment. Without previous experience of stroke, physiotherapy or treatment management, patients seemed to lack insight into the uncertainty of stroke recovery or how to set short-term treatment goals to monitor progress. They also seemed unaware that the physiotherapists needed their help in managing treatment towards a mutually satisfactory outcome.

The findings of the present study appeared to echo the concerns of Playford et al (2000) and Stachura (1994) that much of the rehabilitation process including goal-setting and treatment choices was beyond the comprehension and control of patients because it was conceived and managed by physiotherapists and other rehabilitation health professionals. However, the present study has appraised the problems of communication in physiotherapy treatment across the entire period of treatment and not just at the more commonly examined goal-setting and treatment implementation stages. This broader focus has highlighted some important perceptions of physiotherapists regarding patients' understanding of stroke and their ability to become involved in treatment. It has also generated speculations on how patient's understandings might develop over time as their self-awareness progressed. This might be an important issue with reference to the planning and implementation of strategies to support shared understanding and partnership in treatment.

The physiotherapists agreed that for many patients the stroke event was a new and unexpected experience. They also recognised that in the acute stages, patients' mental and physical frailty often prevented them engaging with any aspect of the stroke and its treatment and any other support provided. In view of these constraints to patients' active involvement in the management of treatment, the physiotherapists acknowledged that they often simply carried on and took control in treatment, particularly in the acute stages. In some cases, the most that physiotherapists felt they could achieve in involving patients was to keep them informed of what was being done. In view of these findings, it may be speculated that in order to communicate in partnership with patients about treatment and what their responsibilities might be, physiotherapists would have to assess the patient's own perception of these concepts and their views on their rehabilitation and progress.

The physiotherapy literature suggests that physiotherapists can gain this information by asking patients for their views on the problems the stroke presents for them and the goals they want to achieve (CSP, 2000; Lennon & Hastings, 1996; Bassett & Petrie, 1999). However, the results of the present study suggested that these simple questions might not have much significance for patients with no previous experience of stroke or physiotherapy and with no concept of treatment as a series of discrete problems and short-term goals. In this respect, physiotherapists seemed to possess greater powers of understanding of stroke and its treatment processes than patients. They also seemed to be in possession of more knowledge of how to use this information. It is possible that this advantage might grant physiotherapists the power to take the lead in treatment in accordance with their own goals rather than the patient's wishes.

The implications of these findings for the physiotherapeutic interaction can only be speculated upon at this stage. However, it appears from the data discussed so far that stroke physiotherapy treatment is under the control of physiotherapists and is managed in complex processes that older and less cognitively able patients cannot understand. Moreover, these difficulties appear to be particularly acute in the early stages after stroke. The physiotherapists acknowledged that it was important to have some awareness of the optimum time to approach patients to discuss treatment in light of patients' reduced ability to comprehend information and to understand what had happened to them. However, it may be speculated that extra time is not enough and that the way that treatment is conceived and presented to patients needs to be changed and simplified. This might make it easier for patients to understand information about treatment in the earlier stages. It might also help physiotherapists and patients to communicate more effectively about treatment and to build more effective shared partnerships as treatment progressed.

According to the findings in the present study, physiotherapists felt they might be hampered in trying to achieve a shared working relationship with stroke patients in treatment because they experienced difficulties in expressing in words the way they used their hands to assess and guide the patient's movements and progress during treatment. This finding builds on the observations of MacWhannel (1992), Adams (1994) and Swain (1997) all of whom identified the use of non-verbal tactile processes in physiotherapy. The focus groups in the present study highlighted how tactile processes were a central part of physiotherapy treatment. They also explained how therapists used them to gather information about the patient's movement ability and to appraise the effect of treatment and to consider other treatments.

The significant concern about the tactile processes in physiotherapy seems to be that although this is evidently an important part of treatment, it is not being made obvious to patients what is happening to them. This is probably partly due to the way tactile treatment processes seem to be integrated with the therapist's supportive touch and movement of the patient's body during treatment. Physiotherapists acknowledged that they find it hard to translate the more specialised aspects of treatment and its plans into a form that patients might be familiar with and could easily understand. Interestingly, some bodies of literature such as Foucault (1982) and Cheung & Yam, (2005) might describe such physical control techniques as strategies of confining power. This interpretation suggests that a focus upon the social power meanings of therapeutic processes might help to explain why shared working patterns may not be developing between therapists and patients in practice.

The physiotherapists in the study appeared to be frustrated by many of the problems that prevented them communicating and working more closely with patients during treatment and were keen to explore ways that shared understanding and responsibility in treatment could be promoted. Some of the suggestions made have been addressed in previous studies, for example, shared goal-setting (Baker et al, 2001) and giving honest information about progress (CSP, 2000). However, the physiotherapists in the study also proposed that adopting a bargaining strategy might help to make patients become more aware of the specialised aspects of treatment, such as balance work, whilst also motivating them with the prospect of practising their own preferred activity of walking.

This again is a very interesting observation because of its social power undertones. It was speculated in the focus groups as something which could promote patient involvement in the plans of treatment by raising their awareness of what the therapists considered important in treatment.

The concept of raising the patient's awareness in treatment might be useful in supporting their ability to become more active in the therapeutic partnership as Feste (1992) suggests. However, it may be that a bargaining strategy might also have the underlying effect of coercing the patient to comply with the plans of the physiotherapist. This may be another example of unintentional control by health professionals through the normal processes of care and treatment as Stachura (1994) and Playford et al (2000) observe.

The therapists in this study discussed the idea of using written contracts in different forms to facilitate discussion of the plans of treatment with patients and the negotiation of expected obligations and duties. These were conceptualised as informal daily plans of problems and treatment goals which the patient could retain at their bedside and were conceptualised as a formal agreement of the part each would take in treatment. This clearly reminds one of the negotiated partnership agreements referred to in the literature by Quill (1983), Law et al (1995) and Charles et al, (1999) and which some authors (Robson, 2002; O'Boyle, undated) among them referred to as 'concordance'. The physiotherapists considered strategies to help patients to understand that treatment was something they took part in. They also discussed how patients could be supported in feeling able to ask questions and being able to control communication interaction themselves. The negotiation of an agreed contract in treatment may enable patients to feel more involved and aware that they have much to contribute to the plans of their rehabilitation.

It may be that strategies to break down the social barriers influencing healthcare interactions as the literature suggests (Waterworth & Luker, 1990; Williams & Harrison, 1999) may be the only way forward. This may be important considering the predominantly elderly stroke population who are likely to expect to have a deferential relationship with healthcare professionals. However, as little is known of how these social barriers are formed and used in the physiotherapeutic treatment interaction it is evident that further research is necessary into the social power dynamics taking place between therapists and patients as they work together in pursuit of their own plans.

4.7 Conclusions summary and consideration of questions for next study

The stage one physiotherapist study explored the barriers preventing partnership working between patients and physiotherapists in stroke rehabilitation from the perspective of physiotherapists involved in this service. It also sought to explore the views of physiotherapists regarding interventions that may enable and support effective shared therapeutic partnerships. The study generated a considerable body of data, some of which confirmed the magnitude and complexity of the problems faced by physiotherapists and patients in working together in treatment with a shared purpose.

The findings demonstrated that therapists were aware that they were in possession of resources which enabled them to have control over the nature of treatment and the way it was carried out with patients. The key resources that the physiotherapists identified they had were knowledge and understanding about stroke, its rehabilitation and recovery and experience and competence in the processes of the plans and activities of physical therapy treatment. In contrast, the physiotherapists noted that the predominantly elderly population of stroke patients often had little or no knowledge, experience or comprehension of the processes and plans of rehabilitation.

The therapists acknowledged that these factors may contribute to patients' inability or reluctance to take an active part in managing their rehabilitation treatment. In this respect the study confirmed the fallacy of promoting empowerment of patients and partnerships in treatment without the provision of guidelines and practical support to overcome many of the common problems that prevent these being implemented successfully. However, it is also important to note that inequality in knowledge and clinical management ability in favour of the healthcare professional is probably an unavoidable state of affairs in most cases and should not necessarily indicate an imposition of power over patients.

However, one observation made in the study did suggest that physiotherapists may use their power to influence the patient and the course of treatment in physiotherapeutic interactions. The physiotherapists demonstrated their frustration with patients who decided to decline treatment altogether. They made it clear that such apparently irrational choices did not accord with their own expectations of patients in rehabilitation and they asserted that they might in intransigent cases exert intense pressure upon patients to encourage them to accept treatment. This forcefulness was justified by the therapists on the basis of their insistence that refusal of treatment was likely to have an adverse effect upon the patient's chances of useful rehabilitation after stroke. This is an interesting finding as it illustrates something of the way that physiotherapists and patients might use their different forms of power to try to achieve their individual aims in treatment interactions. The example also shows how therapists' and patients' aims and strategies to achieve those aims might be in conflict and how difficult interactions such as this might influence the working relationship in treatment.

There is little indication that physiotherapists and patients understand each other or are able to communicate with each other about what they are doing in making these choices and why. This leads one to question what is actually taking place in treatment interactions and to wonder about the different understandings and strategies that physiotherapists and patients might use to achieve what they want and how this might define the power relations and prospects for effective partnership working in stroke physiotherapy.

4.8 Reiteration of aims of stage two study

The questions discussed above at the conclusion of the stage one study formed the basis for the stage two study which sought to conduct an in-depth examination using qualitative case study methods of the ways that therapists and patients utilised power in the stroke physiotherapy treatment interaction in pursuit of their own plans. From these data, the study hoped to model how such strategic interactions were influencing the development of partnership working. It was intended that these insights would be used to suggest how more productive negotiated partnerships could be facilitated.

Chapter 5 Results part one: summaries of combined case studies and interpretative discussion of 'negotiation of leadership' and 'treatment activities interactions'

5.1 Introduction

This chapter presents the first part of the results of the stage two study. The study has sought to use a symbolic interactionist approach to examine how physiotherapists and stroke patients understand and use their power in out-patient treatment interactions to achieve their own plans to explain how this influences partnership relations that emerge between them. From these data it was intended that a working model of the strategic social power dynamics of physiotherapy treatment interactions would be produced and furthermore, that these conclusions would inform the development of a social interactionist model of partnership working in the physiotherapeutic encounter. Further development of these models is demonstrated in association with the interpretative analysis and discussion of the combined primary and secondary case study data in the course of the next three results chapters and the final general discussion chapter.

The final study was carried out in two stages: a primary study of original research and a supplementary study involving secondary analysis of an existing set of data related to this project. Throughout the remainder of the thesis these studies will be referred to as the 'primary' and 'secondary' studies. The results of the combined primary and secondary studies will be presented in three chapters. The present chapter will first outline the four key themes identified from the analysis of the combined data of the primary and secondary studies. It will then provide summaries of the demographics and contexts of the primary and secondary case studies. The present chapter will conclude by presenting the data from the primary and secondary case studies relating to two of the key themes: the 'negotiation of leadership' and 'treatment activities interactions'. The data from the combined case studies will be presented in the form of an interpretative discussion of the themes and sub-themes identified. The discussion of these themes will be supplemented with illustrative excerpts from the relevant primary and secondary data. Chapters six and seven respectively, will present and explain the results relating to the two remaining themes: 'communication interactions' and 'social interactions'.

Presenting the results in this format will explain the meaning of each theme and will illustrate how each was interpreted from the particular data that are shown. The value of the knowledge gained from the data will also be discussed in the development of a theory of strategic social interaction and partnership in stroke physiotherapy. The models of strategic power interactions and partnership working developed in the physiotherapeutic encounter and their implications for physiotherapy professional practice and patient participation in stroke rehabilitation will be presented and critically appraised in a separate general discussion chapter with reference to the current literature on the ideals of 'expert patient-hood' and partnership.

The primary study utilised qualitative case studies, each comprising observation of one out-patient (day hospital) physiotherapy treatment session and one follow-up interview each with the patient and the therapist involved. The secondary analysis study utilised some of the qualitative sets of data of a study related to the present research, each set making up a 'case study' comprising an observation session of an out-patient physiotherapy treatment session and a follow-up interview with the patient and therapist involved.

5.2 Participant demographics

5.2.1 Key to demographics and case study data presentation

In this and the following two results chapters the demographics and primary and secondary case study data are presented using some abbreviations and identification labels. These marks are used to ensure consistency in referencing the identity and source of the data and will be explained here. The six primary case studies are identified by the code letters CS and a number 1 to 6, for example: CS-1. The site codes of the different study sites the participants were recruited from are denoted by the letters A, B, C, and D. The abbreviation 'DH' used in Tables 3 and 4 means 'day hospital'. Where quotations of the primary data are used in the present chapter and chapters six and seven, the sources of the data will be given in brackets after the quotation. This information will comprise the case study code and number as described above (e.g.: CS-1) and a statement of whether the data are treatment session transcript, field notes, patient interview or therapist interview data.

The four secondary data-sets or case-studies as they will be called are identified by the code letters SCS and the number labels used in the original study, ie: SCS-001, 002, 006 and 007. The session numbers documented in brackets in Table 5 identify whether the data-sets used for the secondary analysis are from the first (Obs-1) or second (Obs-2) observed treatment sessions of the longitudinal case studies conducted in the original study. Where quotations of the secondary data are used, these will be presented following the same format as outlined for the primary case studies.

5.2.2 Demographics of the primary data

Six patients and five physiotherapists participated in the six primary case studies, one of the therapists taking part in two of the case studies. Four of the patients were male and two female and their ages ranged from 43 to 83 years, the mean age being 66. One relative, the wife of the patient in the fourth case study (CS-4) asked to be able to contribute in the follow-up interview with her husband. She read the study information sheet and gave her written consent as an additional participant in this case study. No demographic details other than gender and relationship to the patient were recorded for this additional participant. Of the five therapists who took part in the study, one was male and the rest female. Their ages ranged from 23 to 46 years, the mean age being 33. Full demographic details of the patients and therapists who participated are documented in Tables 3 and 4 below. The demographic data summarised in the tables are derived from the field notes, observation session transcripts and therapist and patient interview transcripts of case studies one to six.

Table 3. Primary data patient demographics

Case study & (site codes)	Patient gender	Age	Side of stroke	Date of stroke	Duration of DH therapy
CS-1 (site A)	Female	83	Right-side weakness	2002	17 months
CS-2 (site B)	Female	79	Left-sided weakness	August 2003	8 months
CS-3 (site A)	Male	67	Right-side weakness	February 2004	4-6 months
CS-4 (site D)	Male	43	Right-side weakness	Missing data	8 months
CS-5 (site D)	Male	47	Right-side weakness	August 2004	3-4 months
CS-6 (site C)	Male	75	Left-side weakness	July 2002	approx 1 year

Table 4. Primary data therapist demographics

Case study & (site codes)	Therapist gender	Age	Therapist grade	Date qualified	Time worked with patient
CS-1 (site A)	Male	23	Senior II	2001	3 months
CS-2 (site B)	Female	36	Senior I	1989	8 months
CS-3 (site A)	Female	25	Senior II	2000	7 sessions
CS-4 (site D)	Female	33	Senior I	1993	8 months
CS-5 (site D)	Female	33	Senior I	1993	3-4 months
CS-6 (site C)	Female	46	Senior I team leader	1980	2 years on & off in DH & other services

5.2.3 Demographics of the secondary case studies

Of the four patients involved in the selected secondary case studies, three were female and one male. Their ages ranged from 53 to 79 years, the mean age being 67. Five therapists took part in the four selected treatment sessions, two in the one (002) session and one in each of the other sessions. Of the five therapists involved, one was male and the rest female. Of the two therapists who took part in the 002 treatment session, one was a junior grade and the other a senior. No other information on the grades or ages of the therapists who participated in the study was available in the data. All of the treatment sessions in the selected 'case studies' took place at the out-patient stage of the patients' rehabilitation in either the hospital neurological gymnasium or in the day hospital treatment setting. Information on the duration of the patients' out-patient/day hospital treatment at the time of the recorded treatment sessions was not available. The available demographic data for the selected cases are summarised in Table 5 below.

Table 5 Secondary data participant demographics

Case codes (Session No.)	Patient gender	Age	Side of stroke	Date of stroke	Site of out-patient therapy	Therapist gender	Therapist grade
SCS-001 (Obs-1)	Male	73	Right	1999	Day Hospital	Female	Not known
SCS-002 (Obs-2)	Female	62	Left	1999	Neuro-gym	Female Female	Junior Senior
SCS-006 (Obs-2)	Female	79	Left	1999	Day Hospital	Male	Not known
SCS-007 (Obs-2)	Female	53	Right	1999	Neuro-gym	Female	Not known

5.3 Definition of key themes and sub-themes identified in the combined data

Within-case and cross-case thematic analysis of the primary and secondary case studies produced evidence that the interactions of physiotherapists and patients in the treatment sessions were orientated in four main forms. These were:

1. Negotiation of leadership
2. Treatment activities interactions
3. Communication interactions
4. Social interactions

The identification of these four interaction elements suggested that the treatment sessions were structured by the interactions of the therapists and patients as they each tried to achieve the things they wanted. Thus, it can be seen that the treatment session interactions involved agreement between the participants of who led the session, activities of physiotherapy treatment, communication between the participants and social interaction. The four interaction forms will be called 'interaction structures'. There did not appear to be any clear order in the way that the four interaction structures took place in the case studies and the 'negotiation of leadership' interaction did not emerge in all of the secondary case studies. The way in which these four themes and their meanings were derived from the primary and secondary case studies in the within-case and cross-case analyses will be outlined next. This will provide a clearer understanding of the definitions of the interaction structures. It will also show how these concepts led to the identification of sub-themes in the data called 'strategic control negotiations' which are the meanings of power that therapists and patients identified with and used in their interactions as they negotiated for control of the interaction structures to achieve their aims. It is intended that this will support the credibility of the interpretative analysis processes carried out in the development of the theories in the study.

In the within-case analysis, the data from each of the primary and secondary case studies were coded to map out the meanings which could be interpreted. The early codes produced in the first three primary case studies were compiled into an early analytic framework. This highlighted the different kinds of interaction which took place in the sessions as well as the aims of the participants and what each seemed to do to try and achieve their aims. It also documented the involvement the participants had in treatment and explained the understandings which each had of their role and power. The therapist and patient interview topic guides and the observation schedule were used as initial reference points for the development of this framework as they outlined the main research questions of the study and provided working definitions which supported the identification of the different interaction forms in the data. The treatment session transcripts and field notes data were the main sources from which the interaction structures were interpreted whilst the interview data provided the clearest information about the expressed aims of the participants. However, the field notes and the treatment sessions transcript data were also used to provide information about the aims of the participants, for example as the therapist instructed the patient about what exercise they would do and why.

The treatment session field notes and audio-transcript data revealed how the interactions between the therapists and patients were orientated in three main forms. These interaction forms were identified as treatment activities, communication and social interactions. Progressive within-case analysis of the data showed that the communication interactions involved discussion and non-verbal processes in which the participants exchanged and bartered for information to support their aims; the treatment activities interactions were initiated mainly by the therapists who used touch and verbal control processes to control the patient's body in pursuit of therapeutic aims; the social interactions were identified as instances when the participants stimulated social communication with humour for example or suppressed social communication with social distancing. The treatment session field notes and audio transcript data also revealed another theme but this was difficult to define in the early stages of the analysis. The interpretations gained from the individual case studies broadly suggested that the therapists and patients were expressing their individual perceptions of authority to each other as they worked together. These interactions seemed to have a purpose in that they affirmed who controlled the treatment sessions. As the analysis progressed and these interpretations were compared across the combined case studies, it could be seen that these interactions were negotiations of the leadership of the treatment sessions.

As the instances of the interaction structures were developed in the cross-case analysis of the combined data, it was evident that the therapists and patients were using the different interactions of authority, tactile treatment processes, communication and social interactions as strategies to try to achieve particular things in the sessions. Information about the participant's different aims was sought in the data to assist in the interpretation of the strategies in the interactions. The different aims and strategies that were used by the participants in the interactions were mapped out in a cross-case analysis using charts. This charting of the data highlighted that there were underlying meanings of power in what the participants were doing to try to achieve their similar therapist and patient goals. These meanings were developed further with reference to the participants' own interpretations of their power in the interview data. This showed that the therapists and patients were using different strategies in the interaction structures as negotiation tools to influence the other participants in the treatment sessions in pursuit of their own goals. The participants' strategies which were identified as sub-themes of the interaction structures were called 'strategic control negotiations'. An example of a strategic control negotiation in the communication interaction structures was the therapist's gathering of information to manage the patient and their treatment to achieve therapy goals and professional satisfaction.

5.4 Summaries of the primary and secondary case studies

In this section the primary and secondary case studies will be summarised to outline the context and other background details of each case. In the primary case studies these data were sourced from the field notes, treatment session transcripts and interview data. In the secondary case studies, these data were drawn from the field notes and personal profile data which had been collected as demographic data in the original study. Summaries of the aims of each of the participants in the case studies will also be presented. In the primary case studies this information was derived from the interview data as the therapists and patients were each asked in interview to reflect upon what they had been trying to achieve in the particular treatment session. In the secondary case studies, the treatment session transcripts were also used to interpret participants' aims if these were not openly stated in the interview data. Understanding something of the aims of the participants in the case studies was intended to help clarify the meanings and purposes of the strategies that were used by therapists and patients in the treatment interaction structures. This should also have helped to ground the analytic interpretations of the data back to the participants' own meanings of what they were doing and what they were trying to achieve in their interactions in the sessions.

Case study 1 (CS-1)

The observed treatment session in case study 1 took place on 29/04/04 in the main treatment gym in the day hospital at study site A. The demographics in Tables 3 and 4 show that the participants in case study 1 were an 83 year old female patient and a 23 year old male physiotherapist. The patient had suffered her stroke in 2002, which had affected her with a right-sided weakness. She had been attending the day hospital for 17 months, but had only been treated by this therapist for the last 3 months. The therapist stated that the patient's treatment was probably nearing its conclusion. The therapist was working at a Senior II grade and had been qualified for 2½ years. One other participant took part in this treatment session. This was a therapy assistant whom the therapist confirmed was involved in supporting his therapeutic work with the patient. The therapy assistant consented to her participation in the treatment session being recorded and used in the study. She did not take part in a follow-up interview and her aims in the treatment session were not recorded. For these reasons and because her activities were under the authority of the therapist, her interactions in the study will be presented in conjunction with the therapist data.

The therapist in this case study described his aims as being to improve the patient's walking gait, trunk stability and transferring ability. The patient's aims were to do her best in treatment with reference to the therapist's aims.

Case study 2 (CS-2)

The treatment session in this case study took place in the day hospital at study site B on 11/05/04. The session activities were held in one of the treatment gyms at the day hospital and in another smaller room set up as a bedroom. The case study participants were a 79 year old female patient and a 36 year old female physiotherapist (see Tables 3 and 4). The patient had suffered her stroke in August 2003, which had left her with a left-sided weakness. The therapist had qualified in 1989 and was working at a Senior I grade. The therapist said she had worked with the patient for 8 months at the time of the study.

The physiotherapist in this case study explained that her aims were to 'catch-up' on the patient's progress after a break in contact, to improve the safety of the patient's standing transfers and to persuade the patient of the risks to her safety in wishing to live alone at home. The patient's aims were to progress in being able to walk, to get stronger arm function and to go home and live alone.

Case study 3 (CS-3)

The treatment session in case study 3 occurred on 05/07/04. The setting was the large open treatment gym in the day hospital at study site A. The patient in the CS-3 case study was a 67 year old man who had suffered his stroke in February 2004 which had left him with a right-sided weakness. The therapist in the session was a 25 year old woman who had qualified in 2000 and who was working at the time of the study at

Senior II grade (Table 4). The patient had been having day hospital treatment for four to six months and had been treated by this therapist for seven sessions (Tables 3 and 4).

The physiotherapist in this case study said her aims were to assess and improve the pain and range of movement of the patient's shoulder and to work on the fine motor function of his hand. The patient explained his aims as to regain complete fitness and to have use of his hand and arm again.

Case study 4 (CS-4)

The treatment session in case study 4 took place on 20/01/05. The setting for the treatment session was the main day hospital treatment gym at study site D. The participants in this case study were the patient, the therapist and the patient's wife. The patient, a 43 year old man, had suffered a stroke which had left him with a right-sided weakness. The date of the patient's stroke was not recorded. The therapist was a 33 year old woman who qualified in 1993 and who was currently working at Senior I grade in the day hospital. The patient had been attending day hospital therapy for 8 months, during which time he had been treated by the present therapist. The patient's wife also attended the observed treatment session and was an active contributor.

The physiotherapist in this case study described her aims as being to improve the function of the patient's foot and to treat its sensitivity to raised tone. The patient said his aims were to do whatever was necessary to achieve the best recovery possible. The patient's wife said she wanted to provide support and a voice for her husband and that she wanted to learn about the therapy that was to be carried out at home.

Case study 5 (CS-5)

The treatment session in case study 5 took place in the day hospital treatment gym at study site D on 16/02/05. As shown in Tables 3 and 4, the participants in this case study were the patient who was a 47 year old man and the therapist who was a 33 year old woman. The patient had suffered his stroke in August 2004 which had affected him with a right-sided weakness. He also demonstrated marked expressive difficulties in his communication. The therapist was the same one that had taken part in case study 4 and so her demographic details will not be repeated here. The therapist reported that she had been treating the patient in the day hospital for about 3-4 months on a weekly basis.
The physiotherapist in this case study explained that her aims were to reduce the patient's use of a splint on his affected foot and to treat the pain in his shoulder. The patient experienced difficulties in expressing his aims because he suffered from severe

expressive communication problems. However, despite these difficulties, the patient indicated through actions and supported word prompts that he wished to use his arm, leg and foot again.

Case study 6 (CS-6)

The treatment session in case study 6 took place on 08/03/05 in the main treatment gym at study site C. Taking part in the case study were the patient who was a 75 year old man and the therapist who was a 46 year old woman. The demographics in Tables 3 and 4 show that the patient had his stroke in July 2002 which affected him with a left-sided weakness. The therapist who qualified in 1980 was graded as a Senior I Team Leader. Although the patient had been having day hospital therapy for the past year, the therapist had worked with him on and off for 2 years in different therapy services, including in-patient, out-patient and domiciliary.

In this case study the physiotherapist's aims were to review the patient after a period of intensive therapy, to assess his back pain problem and to persuade him to become more independent in his mobility without a wheelchair. The patient's aims were to obtain treatment from the therapist for physical discomforts to enable him to progress in his group therapy.

Secondary case study (SCS) 001

The treatment session in this case study took place in the Day Hospital treatment gym. As noted in Table 5 the participants were a 73 year old male patient who had suffered a right-sided stroke in 1999 and a female physiotherapist. The field notes data show that the therapist was working in this single treatment session as a locum practitioner and not as a permanent member of staff.

The aims of the physiotherapist in this treatment session were to obtain information on the patient's life with stroke and to inform the patient about his incomplete recovery. The patient's aims were recorded as a wish to return to normal or to achieve limb movement which could be worked on at home to achieve further recovery. Being able to play golf again was stated as a bonus goal.

Secondary case study (SCS) 002

The venue for the treatment session in this case study was the gym in the out-patient neurological rehabilitation service. As Table 5 shows, the participants were a 62 year old female patient who had suffered a left-sided stroke in 1999 and 2 physiotherapists.

The therapists were both female. The patient's main therapist was a 'junior' grade and the other therapist a 'senior' grade. The field notes record that the 'senior' therapist was involved in the treatment session in a consultant role at the request of the 'junior' therapist. No further information was available in the data about the professional status of the therapists. To assist in differentiating the two therapists in the text, the patient's main therapist will be identified as 'therapist 1' and the senior consultant therapist as 'therapist 2'.

In this case study, the aims of therapist 1 were to help the patient to achieve a basic level of supported walking and to conduct an assessment to make a decision on a treatment break. The patient's aims were to walk, to get back to normal and to regain the ability to do what she wanted. The aims of therapist 2 were not stated in the data but she appeared intent to conduct her consultation of the patient's case in a timely fashion and to continue with her own patient case load.

Secondary case study (SCS) 006

The treatment session in this case study took place in the Day Hospital treatment gym. The participants were a 79 year old female patient who had suffered a left-sided stroke in 1999 and a male physiotherapist. The therapist reported in his interview that he had been working with the patient for 3 months at the time of the study taking place.
The physiotherapist's aims were to discharge the patient that day and to review her in 3 months time. The patient's aims were to be able to walk down stairs at home and to use the bus in order to go shopping. The patient also wished to be able to write again and aimed to pursue private therapy to meet this goal.

Secondary case study (SCS) 007

The treatment session in this case study took place in the out-patient neurological rehabilitation treatment gym. The participants were a 53 year old female patient who had suffered a right-sided stroke in 1999 and a female physiotherapist.

The aims of the physiotherapist in this session were to achieve improvements in the patient's walking and shoulder function. The patient's aims were to be able to walk independently.

5.5 Presentation and interpretative discussion of the data relating to 'Negotiation of leadership' theme

This section will present and explain the data from the combined primary and secondary case studies that relate to the 'negotiation of leadership' theme. Using quotations from the data, it will discuss the meanings of the strategic control negotiations that were used by the therapists and patients in the 'negotiation of leadership' interactions as they pursued their individual goals in the sessions and how this influenced the degree of partnership working between them.

The data showed that as the therapists and patients worked together in the treatment sessions, they engaged in negotiations over the leadership of the sessions. This theme was identified in all of the main case studies (CS-1 to CS-6) and in two of the secondary case studies (SCS-001 and SCS-002). The data in the SCS-006 and SCS-007 cases did not appear to manifest any clear examples of negotiation of leadership. As this theme was not the focus of the original research from which the secondary data were sourced, perhaps it is not surprising that it did not emerge in all of the secondary data-sets sampled. In trying to understand the meaning of the negotiation of leadership interactions it is necessary to consider more closely the evidence of how the strategy was used. Moreover, consideration of the motives of the physiotherapists and patients in acting as they did in the leadership negotiations may explain how important these decisions were in establishing the roles and power relations which underpinned the other interactions in the sessions.

In those case studies in which the negotiation of leadership theme was identified, the physiotherapists and patients approached these interactions in very different ways and this probably highlights the different conceptualisations of institutional authority held by professionals and lay people. The chief strategy that was used by the therapists to 'negotiate' leadership of the sessions with patients and colleagues was expression of professional authority. Not all of the patients seemed to be involved in interactions of authority with the therapists, but those who were showed their approval of the physiotherapist's leadership in their compliance and keenness to help. A closer examination of the evidence in each of the case studies will help to define this thematic concept more clearly. It will also provide some insight into the significance of this interaction in the development of partnership relations.

5.5.1 Therapists' use of professional authority to negotiate leadership

The data showed that the physiotherapists across most of the combined case studies exerted their professional authority to assert leadership in treatment on the basis of similar understandings of why such control was necessary. These understandings were that it was necessary to make the best use of limited time available in sessions; that it was part of patients' expectations of them and that it was necessary to manage relations with other therapists of different grades. This section will discuss these strategies in detail with reference to the case study data.

5.5.1.1 Therapists' use of professional authority to manage time

Several of the physiotherapists in the case studies demonstrated that they were concerned about the problem of limited availability of time and that this was an important reason for their establishing leadership of the treatment sessions. In her interview, when questioned about the problems of limited time the CS-3 physiotherapist acknowledged that:

"time is always an important factor...when you want to make your...session as effective as possible and as time efficient as possible to achieve what you want to achieve" (CS-3 Physiotherapist interview).

Evidently the available time allocated for treatment with patients may not have been sufficient to enable completion of all the physiotherapist's aims. The physiotherapist in the CS-4 case study highlighted that treatment sessions in the out-patient setting were often limited to a scant 30 minutes:

"from a practical working aspect you know I've got a half hour slot to see that patient, they come in, we need to start we haven't got much time to waste" (CS-4 Physiotherapist interview).

With such limited time resources, it is perhaps not surprising that the physiotherapists took charge of the treatment sessions and implemented other strategies to try to control the patient and their participation. In the circumstances of the SCS-001 treatment session the physiotherapist was working with the patient in a one-off treatment session only and this may have influenced her decision to control the session and the patient with brisk instructions about what she wanted him to do:

"do you want to put your shirt back on because I want to have a look at walking" (SCS-001 Treatment session transcript).

The physiotherapist also issued the patient with extensive instructions for home treatment activities she wanted him to pursue and this was probably to ensure that her therapeutic influence would extend as far as possible beyond the limited scope of the short treatment session:

"Okay so that's what I'm going to give you to do at home anyway" (SCS-001 Treatment session transcript).

As the physiotherapist of this case study was limited to the one treatment period with the patient, it seems reasonable to assume that she tried to make the most of this time to ensure that her therapeutic priorities were addressed to her satisfaction in the limited time available. The motivations of the physiotherapist in the CS-2 case study may have been similar as the data show that she used her professional authority to try to deal with her patient's quiet nature, which seemed to threaten the progress of the session:

"I find her quite passive she's often quite slow to initiate things and suggest things but when...offered I appear to be doing what she wants me to do...she's never asked for anything and if prompted sometimes she will...ask for something" (CS-2 Physiotherapist interview).

This physiotherapist justified her authoritative control as a necessary action to enable things to get done in the limited space of time in the treatment session and the following quotation illustrates the therapist's frustration at the patient's persistent passivity and apparent lack of co-operation in the progress of the session:

"I've seemed to take a more sort of...directive role [over the patient] because I feel that if I didn't we could sit there for a long time and ...not do anything and not say anything" (CS-2 Physiotherapist interview).

It is possible that the physiotherapist's directiveness over the patient related more to concerns over achievement of therapeutic and time-management goals rather than concerns about the patient's involvement in treatment. From the patient's perspective, it is possible that she believed she was fulfilling the role that the professionals expected of her as the passively compliant patient:

"all the treatment from all the therapists...gives the impression they are in charge and we do what we're told..." (CS-2 Patient interview).

This does not suggest that the patient was uninterested in getting involved but rather suggests that she recognised that she was expected to go along with the professional's wishes and not to challenge her with her own plans. Ironically, this seems to have been what irritated the physiotherapist who would have preferred a more active patient. Despite the evident inequality in the distribution of authority in this treatment interaction, there is still a sense of negotiation taking place in that the therapist's assertive actions were initiated in response to the patient's passive attitude. The problem may have been that the participants were negotiating conflicting understandings in their interactions as they each tried to do what they thought was expected of them in the session. This would have countered the development of any shared communication or working relations between them. Further examples from the other case studies of patients' demonstrating compliance as a means of fulfilling their own and the therapist's plans are discussed in section 5.5.2.

In the CS-5 treatment session, the data showed that the physiotherapist seemed to be monitoring the clock quite carefully during her activities and this suggested that it was an important priority for her to keep to a planned time schedule:

"let's take...how are we doing for time that's fine. Let's take this shoe and your splint off while you're here" (CS-5 Treatment session transcript).

When this was discussed with her in interview, the physiotherapist acknowledged that time was the underlying factor which limited what she could do with the patient and what treatment activities she could work on:

"we only had half and hour to work with [the patient] and so to try and sort out his shoulder and to try and sort out his foot in half an hour is not really practical so I know that I asked him which out of the two he specifically wanted to work on and he identified that he wanted to carry on working with his shoulder" (CS-5 Physiotherapist interview).

As the patient in the CS-5 case study had severe expressive communication difficulties, it was not surprising that the therapist used her professional authority to manage all the decisions in the session as these issues may have been difficult to discuss with the patient in the limited time frame. However, as the quotation above shows, the therapist helped the patient to choose what was done in the session by giving him a choice of two options. This strategy was evidently intended to support the patient's active participation in his treatment:

"in terms of the plan for the session, I gave [the patient a] choice to start off with as to what he wanted to work on so he had the ultimate decision there...about what we were going to do for the day...so he took responsibility really for the planning...he was in control of that certainly" (CS-5 Physiotherapist interview).

However, it probably also ensured that the discussion about treatment was managed as effectively as possible in the limited treatment time available. The therapist evidently took charge in this session as she managed treatment and the problems of time and the patient's limited communication and her leadership was undisputed as the patient did not offer any objections to her activities. However, as the therapist openly agreed her support of the patient's participation in deciding treatment then the therapist's power and the negotiation process were acknowledged and agreed upon also.

5.5.1.2 Therapists' taking leadership role on patients' expectations

In the CS-4 case study the therapist seemed to suggest that patients would learn about how their treatment was managed and what would be done:

"he'd been coming for many months now and he knows ...what to expect when he walks...into the gym and what...the boundaries are ...of what we will be working on with him and how we're going to achieve that" (CS-4 Physiotherapist interview).

There is a sense here of the therapist's assumption of authority being based upon the belief that she and the patient had reached a shared agreement over a long association in treatment about how the leadership of the session and responsibility for treatment should be distributed. The physiotherapist in the CS-5 case study seemed to express a similar view as she discussed her rationales for using her authority to manage treatment and the patient's severe communication problems. As she explained, she considered her authority to be just part of her professional role and this was something that patients expected from her as the therapist:

"what I do most of the time really...it's something I feel very comfortable with ...because people come to you for advice and for...help really ...so there's already an expectation that you're here to do something...to make something happen ...so it's already indicated that you've got that [power] to a certain extent" (CS-5 Physiotherapist interview).

This view suggests that the physiotherapist had a very pragmatic approach to her work and the authority and expertise she held because she recognised that it was essentially bestowed on her by patients and their expectations of her power in being able to help them. In this case study the role of leader seemed to be acknowledged openly by the physiotherapist in her work with the patient. On the basis of this, it appeared that the physiotherapist's authority was perceived by her to be a tool to facilitate the patient's communication and participation in treatment rather than something which could control the patient.

5.5.1.3 Therapists' use of professional authority to manage colleagues

The data showed that the negotiation of leadership strategy was implemented in differing interaction group dynamics. In the SCS-002 treatment session, leadership was contested between two therapists of differing professional status. The field notes record that the patient's own therapist was a junior grade and she had to interact with a senior therapist whom she had consulted about the patient's treatment. The field notes also record impressions suggesting that the senior therapist's manner with her junior colleague was designed to emphasise the gulf of authority that existed between them:

"I feel that [the junior therapist] found the session difficult as she was waiting for the senior physio to finish with her patient and then come and see [the study patient]...The session actually felt like a lesson for the junior physio rather than a physio session for [the patient]" (SCS-002 Field notes)

The interaction between the therapists in this session seemed to be rather formal and predicated upon the therapists' understanding of their different levels of expertise and professional status. In this respect, the therapists seemed to be involved in a complex power dynamic as they negotiated the different layers of their professionalism in the process of trying to achieve what they each wanted in the session. With reference to the observer's first field notes comment above, it appears that the junior therapist felt powerless in having to wait upon a senior colleague's convenience and could not push her own authority to hurry her up because she needed to maintain the senior's co-operation until she had seen the patient. During her interaction with the junior therapist and her patient, the senior therapist referred to the work she wanted to do with her own patient and took the lead in directing what would be done:

Therapist 1: *"[to junior therapist] what time's your next patient in?"*
Therapist 2: *"well half past"*
Therapist 1: *"Right if you pop [the patient's] jacket top on ...I'll walk [my patient] once more and then I'll just have a quick play around with the parallel bars because I've got time...I'll give you a shout if it's okay"* (SCS-002 Treatment session transcript).

The senior therapist's brisk decision-making behaviour seen in this excerpt may have helped her to dominate the treatment session. Her motives in taking charge of the session may be speculated from this data as being to minimise the time of the consultation in order to return to her work with her own patient. The senior therapist may have been using her professional authority to try to manage the conflicting responsibilities she had that day as clinical advisor to the junior therapist and as therapist to her own patients with limited time resources.

5.5.2 Patients' participation in negotiation of leadership

The data suggested that several of the patients participated in negotiating the leadership of the sessions with the therapists. The patients' interactions suggested that they wanted to express their approval of the therapists' authority on the understanding that this would gain them the expert attention they desired to achieve their individual aims. The patients appeared to use two different approaches in trying to gain the therapist's approval and attention: demonstrating knowledge and initiative and demonstrating acquiescence. The meanings of the strategies with reference to the case study data and their implications for power relations and partnership working will be discussed in this section.

5.5.2.1 Patient's expression of initiative to gain approval

The data showed that in one case study (CS-3) the patient had a belief in his own authority in the gym setting and that he expressed this by being active in helping the therapist with the practical elements of the session management.

"I helped her put the brake on...and I will try and do something or I'll pull the table over... so I get involved the same as I said ...the chair over there...the [microphone] could go on that" (CS-3 Patient interview).

In demonstrating this initiative in the session the patient seemed to be showing the therapist that he was a 'good patient' who was keen to help out where possible and this would have invited the therapist's approval. Having gained the therapist's goodwill with 'good patient' behaviour, the patient could have expected the therapist to respond by giving him her expert attention and support. This would have helped the patient to feel that he was making progress towards his goal of recovery In effect, the patient was negotiating his support of the therapist's expert management of treatment in order that he might continue to benefit from this and achieve the complete recovery he desired. The patient's assertion that he had helped the physiotherapist in 'putting the brake on' in the session was not corroborated in the field notes. However, it is possible that either this occurred in another treatment session or the patient's helpful activity was missed as I was writing. The patient's suggestion about replacing the tape recorder microphone on a chair during the session was confirmed in the field notes.

This patient seemed to demonstrate remarkable confidence in the treatment setting and in his interactions with the physiotherapist. When asked what he felt about his position in the treatment gym the patient showed that he had no qualms about expressing himself freely in his work with the therapist:

"I feel...[the gym is] as much my area as hers when I go in...and I think that's what she likes about it because if there's something different there I think I can use and do...I say well shall we try with that shall we have a go....and I've taken all the different things to her that I use like the stress ball, yoghurt cup...and shown her what I'm doing at home...I expect ...she is learning and picking up more tips" (CS-3 Patient interview).

The field notes confirm that the patient demonstrated confident interaction with the physiotherapist at certain times for example as they were seated side by side at a table and he showed her what he had been doing in his hand exercises at home. However, the field notes also record that the patient was quieter and more passive during a shoulder assessment activity when he was lying down. These data suggest that the patient was acting in accordance with understandings of what the therapist expected of him in the different treatment processes. In interview, the patient suggested that his ability to work with the therapist stemmed from his experience in gymnastics:

"I think there's ...a little bit advantage with me because I've done training with the gymnasts" (CS-3 Patient interview).

From this comment and the previous one it appeared that the patient believed that a shared understanding had developed between the therapist and him about what he was allowed to do to help himself and the therapist in treatment. In this respect, the patient was using his prior gym experience as a negotiation tool to demonstrate his worthiness as a knowledgeable, keen and compliant patient to gain the therapist's approval. With this in his possession it is possible that the patient felt that he was getting more from his treatment and making progress towards his goal of complete recovery. It is possible too that the patient felt a degree of pride in gaining the therapist's respect for his prior knowledge of gym training.

5.5.2.2 Patients' acquiescence with therapists' authority

The data showed that in some of the case studies, the patients demonstrated their acquiescence with the authority of the physiotherapists. The patients' motivations for acting in this way were identified as being to acknowledge and support the therapists' authority as they believed this would help them to achieve their wishes for progress and recovery. Despite his assertions of knowledge of movement training and experience in the gym, the CS-3 patient also showed that he deferred to the physiotherapist's judgement because he felt that her knowledge was the thing that would help him:

"Yes I've got my goals...and I want to do it if I can ...but I should work on it the way they want me...to do it...because it is important to do it right" (CS-3 Patient interview).

The patient who took part in the CS-1 case study explained what she thought her role was in her treatment:

"I...try and do my best at all these [treatment] sessions you know" (CS-1 Patient interview).

To achieve her best, the patient showed that she relied upon the therapist's orders:

"I like to continue with what he wants me to do" (CS-1 Patient interview).

It is possible to speculate that this patient's decision to rely on the therapist's expert power may have stemmed partly from the confidence gained from their interaction in therapy. However, it may also have resulted from the patient's own social bias against pushing herself forward in the institutional setting as the patient seemed aghast when she was questioned during her interview about her views on whether she took charge of anything during treatment:

"That I'm in charge?...Oh I don't feel anything is you know...No I think it's all due to what they...telling you...I've never been one to go in for....exhibitions or that...I've always steered clear...because I've been too nervous to do it all you know" (CS-1 Patient interview).

Whilst the patient evidently had some difficulty in expressing what she wanted to say here, the meaning seemed to be that she did not feel comfortable with taking charge of anything to do with her treatment as this was the therapist's role and moreover, she was not one for making an exhibition of herself. As the demographics in Table 3 show that this patient was an elderly lady of 83, it is possible that her reticence in pushing herself forward in treatment may have been a generational social constraint. The patient's acquiescence to the therapist's authority could be interpreted as her part in the negotiation of the leadership in the session as this was evidently an act of choice based on her social beliefs of what was expected of her and was therefore not coercion.

In the CS-4 case study, the patient was a younger man, but he also asserted that he deferred to the physiotherapist's leadership:

"when I go through the session that [therapist's name]...she'll take control and ...so I'll follow her lead" (CS-4 Patient interview).

The patient justified this decision in his next statement:

"I don't really know a lot about it so I'm going there under the expectation that she knows what she's doing, so she takes control ...and that's good by me" (CS-4 Patient interview).

From these data, it is possible to conclude that the patient's acknowledgement of the therapist's expertise and authority in his treatment was a rational choice based upon his perception that this was the best way to achieve the progress he desired in rehabilitation. The patient's act of compliance may therefore have been interpreted by the therapist as a statement of agreement with her leadership in unspoken negotiation as he evidently granted this to her in grateful trust. It seems possible that the acquiescence of this young man may have been influenced by a feeling of gratefulness and trust in the therapist's power and ability to help him achieve his goals.

In the SCS-001 case study field notes, the observer noted that:

"A rapport was built up immediately between [the patient] and the physio. The physio had worked on the rehab ward [the patient] had just come from and she knew the physio and some of the patients [the patient] was talking about" (SCS-001 Field notes).

This observation was echoed generally throughout the treatment session transcript data and it is possible that this rapport was influential in leading the patient to trust the therapist's authority. The patient commented upon his decision to trust the therapist's leadership in his treatment, saying:

"I'm...getting confidence in [the physiotherapists]...I'm quite prepared to go along with the system that she seems to have in mind for me to try these other exercises and ...get the stiffness out of this leg and if that's successful ...then I'll be prepared to go a lot further with home exercises and more physiotherapy to get back to how I was" (SCS-001 Patient interview).

The patient's trust in the therapist and her colleagues and his preparedness to acquiesce fully with their treatment seemed to be something which had developed over time with his confidence in their ability to give him the progress he wanted. This also seemed to have some influence over the patient's confidence in his own ability to carry on with his physiotherapy at home. The evident social connection between the therapist and the patient in the treatment session may have been a contributory factor in the patient's negotiation of his trust and confidence in the therapist.

The evidence in these case studies suggests that the patients all expressed agreement through their acquiescence with their therapists taking the leadership role. Although this agreement seems generally to have been unspoken, the fact that the patients went along with the therapists' plans suggests that they were acknowledging the authority of the professional and using it as a means to progress towards the recovery they desired. In this respect, it could be said that through their acquiescence they actively negotiated their consent with the therapists' leadership.

5.6 Summary and conclusions of negotiation of leadership interactions

The data showed that the therapists negotiated for the leadership of the treatment sessions with the patients by expressing their professional authority. This power was recognised by some of the therapists as being sanctioned by the needs of the institution and by the patients' expectations of expert treatment and help towards recovery. Analysis of the therapists' motives for attaining leadership status revealed that they wanted to be able to control the time-course of treatment and their interactions with the patients and professional colleagues. Achieving control of these aspects of the treatment sessions appeared to be important to the therapists because it enabled them to achieve certain key goals in their work. These goals were identified in the data as institutional goals, therapeutic goals and professional goals.

It might be contended that the therapists' use of authoritative behaviour to press their case for leadership of the sessions did not constitute a form of negotiation interaction because it seemed likely to suppress any authority that the patients could muster.

However, the therapists were evidently being open in that they were declaring their authority. Since the therapists were effectively offering the patients the opportunity to agree or disagree with them, then their actions could be argued as being in the spirit of negotiation. In conclusion of this speculation, it appears that the therapists may have assumed that the patients' lack of disagreement was an assertion of agreement with their plans. Whatever the relevance of these speculations, the negotiation strategies used by some of the therapists appeared to be quite forceful and it has to be acknowledged that such direct statements of authority may have provoked the patients to submit. The reasons why the patients generally acquiesced to the therapists' assumption of leadership across the treatment sessions require further consideration. It would be of particular interest to consider their motives for responding as they did and whether these responses were passively submissive or indicative of a strategic choice that would help them to achieve what they wanted. These questions will be discussed further in the general discussion chapter.

5.7 Presentation and interpretative discussion of data relating to 'Treatment activities interactions' theme

This section will present and explain the data from the combined case studies that relate to the 'treatment activities interactions' theme. The meanings of the strategic control negotiations that were used by the physiotherapists and patients in the sessions as they sought their own aims will be discussed with illustrative quotations from the data. Cross-case analysis of the primary and secondary case study data showed that all of the treatment sessions comprised at least one period wherein the physiotherapists carried out some form of therapeutic intervention. These included physical assessment and other more complex treatment interventions. During these activities, all of the physiotherapists and some of the patients used strategies to try to further their individual aims. The strategies used by the physiotherapists were identified as: verbal control strategies to control patient movement for assessment and educational purposes; physical control strategies to control patient movement for assessment, education and safety purposes and motivational strategies to encourage patient compliance and confidence.

The strategies that the patients used ranged from use and control of conversation, pretence of understanding and conceptualising of therapy as sports training. The patients' purposes in these strategies were interpreted as: to comply with the physiotherapists' plans and to ensure achievement of their own plans. However, these aims could be interpreted as being interchangeable in the patients' plans as achievement of one could also have led to progress towards the other. Only a few patients appeared to utilise particular strategies in the 'treatment activities interactions'. However, this may have been due to the fact that some of the participants' strategies could not be defined exclusively within a single interaction typology as communication, treatment activities or social interactions. It is not possible therefore to attach too much significance to the observation that the patients did not use as many treatment activities interaction strategies as the therapists.

5.7.1 Therapists' use of verbal and physical control strategies

The primary and secondary case study data showed that the therapists used common verbal and physical control strategies. These strategies were delivered in a similar fashion across the case studies and appeared to be used for similar purposes in the physiotherapist's therapeutic and professional goals in the treatment sessions. The implication of these findings is that the strategies were stable features of the therapists' control of the treatment activities interactions that were not generally influenced by the interactions with the patients in the sessions. The meanings of the verbal and physical control strategies will be outlined in their typical presentation in the treatment sessions in order to highlight the defining features of how they help the therapists achieve their therapeutic goals. However, they will not be treated as part of the central focus of the thesis because of their stable nature in the treatment interactions between the therapists and patients.

Cross-case analysis of the combined case study data revealed that in all but one of the case studies, the physiotherapists employed a strategy which used a verbal narrative to control the patients' movement. Only in the SCS-006 case study was this strategy not identified. The verbal control narrative was typically used by the physiotherapists as part of their physical assessment of the patients' function. In this process the physiotherapist controlled the patient's movement through a narrative of verbal instructions, directions and corrective feedback. This was often interspersed by pauses as the therapist manipulated the patient's limb in the assessment process, possibly to feel how the muscles were responding to the movement (CS-3 Field notes). One example of the verbal control narrative in the CS-3 case study is given here:

"Okay just lift your head up [pause] and down [pause] can you slide your arm out to the side for me [pause] okay and again [pause] okay and again [pause] okay all the way in [pause] take it out to the side again [pause]" (CS-3 Treatment session transcript).

Another example of the verbal control narrative from the data shows that the verbal feedback which corrected the patients' movement could also include praise, perhaps as a motivational tool or to inform the patient that they were doing the right thing:

"can you lift this arm up in the air good and down and the other one and down okay both together okay and down...Can you find your other hand got it well done and down..." (SCS-001 Treatment session transcript).

It can be seen from these excerpts that the verbal control narrative was quite repetitive and that the patients did not seem to have any part in the process other than to allow the therapists to move them about as he or she chose in the assessment processes. Indeed, it is possible that the focused way that the therapists carried out the verbal control narrative communicated to the patients that their verbal comments and active participation were not expected. This type of strategy, being a central part of the therapists' work is likely to have represented absolute power for the therapists with no expectation of negotiation. The manner in which the therapists interacted with the patients whilst they employed the verbal control narrative suggested that they adopted a more objective perspective of the patient as a body rather than a social being. In this respect, it might be said that the therapists' power in using these strategies was to objectify the patient as a passive body which could be manipulated and controlled to achieve the relevant therapeutic goals. This issue also has relevance in the tactile therapeutic strategies used by the therapists which will be discussed briefly next.

Another commonly used strategy by the therapists in the case studies was physical control. This strategy was implemented in different forms in the data. Some of the therapists used it as part of their physical assessment or treatment intervention processes for example:

"I used hands on pressure to try and facilitate normal movement ...I applied my hand on to his foot to try and realign the foot to enable him to hopefully recruit better motor control of his foot ...and I gave him verbal feedback as well...to guide him as to whether he was using his muscles correctly" (CS-4 Physiotherapist interview).

From this example it can be seen that the physical control process was used in conjunction with verbal feedback on performance and could have an educational purpose as the therapist tried to get the patient to relearn how to control his own limb in a new pattern of movement after the stroke. However, the physical control strategy also had a role in managing patient safety in the treatment sessions for example:

*"getting the patient to move the right leg does jeopardise the stability and the balance of the patient so two people need to be involved so in a way...the sort of supervision or standing close beside is part of a safety issue"(*CS-1 Physiotherapist interview).

The physiotherapist in this case study chose to use an assistant to increase the supervision of the patient's physical activities and this strategy probably helped to lessen the likelihood of the patient suffering a fall during treatment. However, many of the therapists seemed to work alone with their patients and had to use other strategies such as close physical proximity, particularly during exercises where the patients were trying to stand or walk. One example of this is seen in the CS-2 case study field notes:

"the therapist was bent over [the patient] with [a hand] round the patient's left side...as she stood to transfer. (CS-2 Field notes).

The data showed that safety constraints used by the therapists could have some effect upon patients' social interactions in the sessions. One example was the patient who reported that whilst the therapist's close physical supervision reassured her, it also made her: *"feel more inadequate"* (CS-2 Patient interview).

These findings highlight the social underpinnings in all the verbal and physical control strategies which could have negative implications as well as positive ones for the therapeutic interaction and any possible working partnership. As most of the patients were of the older age group, it is possible that the close physical proximity and therapeutic touch used by the therapists in their control strategies might have been uncomfortable to deal with. Furthermore, the implied social impositions of the physical closeness and touch strategies might have been increased by age and gender differences between the patients and their therapists. What is of particular interest is the implication that the therapists seemed to sublimate the social identities of patients as they objectified them as 'bodies' in their pursuit of their therapeutic goals. This suggests that there may be conflicts between the therapists' therapeutic goals and their aims to encourage patients to become 'partners' in treatment, an ideal which surely must be based upon social principles of communication and interaction.

5.7.2 Therapists' use of motivational strategies

The data showed that some of the therapists utilised motivational strategies with their patients during the treatment activities in the sessions. In the CS-5 case study the therapist employed a motivational outcome strategy to encourage her patient to tolerate a painful treatment intervention:

Therapist to patient: *"can you bear with it just for a minute?"*
Patient: *"Yeah"*
Therapist: *"Oh it'll be lovely...just keep thinking of that...nice ultrasound ...on it in a minute it'll really soothe it"* (CS-5 Treatment session transcript).

This motivational strategy encouraged the patient to believe that if he persisted with the treatment activity despite its discomfort, he would earn his reward when the therapist applied some soothing ultrasound treatment to the area. As the therapist was treating the patient's shoulder pain, it is likely that such a motivational strategy was helpful to encourage the patient's effort and endurance. It may also have been intended to increase his likelihood of complying with the painful part of treatment. In the SCS-001 case study the physiotherapist employed a different strategy to encourage her patient's motivation and interest in treatment. In this strategy the physiotherapist applied the knowledge she had gained about the patient's golf-related aims to construct a home exercise plan incorporating golf activities to motivate the patient's enthusiasm:

"I just thought of something else that would be really good for your hand to do at home... get your golf clubs out...the actual holding would be quite good from the gripping point of view...and if you were a keen golfer before it may be locked in a different part of the brain that the memory of swinging the golf club...so just get it out in the garden" (SCS-001 Treatment session transcript).

As the physiotherapist was working with this patient in a single session only, it is possible that she sought to use whatever key information was available about the patient's background and hobbies in her interactions with him to maximise their communication and co-operation in treatment. The treatment session transcript shows that the therapist opened the session by discussing the patient's goal of playing golf again and this was evidently an important aim for her to use in managing the patient's home activities and his motivation. It is possible that the therapist had hoped to encourage the patient to comply with treatment by relating the home exercises to golf as interest in the sport may have motivated him to practise.

According to the field notes of the SCS-007 session, the physiotherapist used praise and enthusiasm to motivate the patient as she carried out various treatment activities:

"Throughout the session the physio praised [the patient] for carrying out the exercises and seemed to motivate her also. The physio ...decided to teach [the patient] to walk a different way...the physio showed such enthusiasm when [the patient] managed to walk without an aid...this...encouraged [the patient] and gave her confidence to walk on her own" (SCS-007 Field notes).

The treatment session transcript data confirmed that the therapist gave the patient some praise during her treatment activities and the patient interview data documented the patient's growing confidence in her progress and the therapist's role in this:

"she's given me ...added confidence that things are going to move on from here" (SCS-007 Patient interview).

The physiotherapist's motivational strategy in this case study seemed to be intended to increase the patient's confidence in her treatment activities. However, as the field notes suggest that the therapist was trying to encourage the patient to learn the new walking technique, the motivational praise may also have been intended to help the patient to comply with this plan.

In considering the different motivational strategies described in the case studies, it appears that they were essentially employed to encourage patient compliance with the different treatment processes. It is notable that the motivational strategies also conveyed positive social messages to the patients through the therapists' expressions of concern and enthusiasm. It is speculated that such social communications may have had the effect of negotiating co-operative interactions with the patients and possibly greater compliance.

5.7.3 Patients' use of treatment interactions to express compliance and motivation

Some of the strategies that the patients used in the treatment activities interactions appeared to be designed to demonstrate compliance with the physiotherapists' treatment and authority. In the CS-2 case study the patient seemed to use pretence to convince the physiotherapist that she understood the explanation that was given about the physical sense of where her 'middle' was despite this vague concept having no meaning for her. The purpose of this seemed to be to go along with the therapist's plans:

Therapist to patient: *"you seem to be more aware of where your middle is...which is ...something we've been working at for months""*
Patient: *"yes"*
Therapist: *"and it seems now that the ...penny's"*
Patient: *"The penny's just dropped"*
Therapist: *"finally dropping....and you've worked out where you are"* (CS-2 Treatment session transcript).

This excerpt suggests that the physiotherapist believed that the patient was aware of what she meant by 'where your middle is' and that she thought the patient understood the significance of this statement for her rehabilitation. However, there was no evidence in the treatment session transcript or field notes data that the patient told the therapist that she did not understand this aspect of treatment. During her interview, the patient confirmed that she did not understand what the therapist meant in talking about her 'middle':

Patient: *"Some of the explanations are not always easy to understand...I mean this...whole business of...my standing...you just don't know where your middle is do you?...that just...doesn't mean anything* (CS-2 Patient interview).

As she did not own up to her lack of understanding, it seems that the patient wanted the therapist to believe that she knew what was going on and to perpetuate the therapist's assumption that she was now achieving something and that all was well. As the patient wished to achieve her best in treatment, according to her stated aims, it is possible that she sought to nurture the therapist's approval for her apparent progress in order to gain more of her attention. In the CS-4 case study, the patient used a strategy which may have had similar motives as he seemed to be deferring to the therapist during treatment in order to maintain her goodwill. When asked in interview about the best time to speak to the therapist when he wanted something, the patient answered:

"I would probably hold back...basically not to be rude or interrupt or whatever...sometimes when she's doing something with my leg or...when she's fiddling with my muscles" (CS-4 Patient interview).

As the patient's stated aims were to do whatever was necessary to achieve his best in treatment, it is likely that this respectfulness in not interrupting the therapist was based on his recognition of her position as the person in charge of his therapy. As such, this respectful approach may have been intended to gain the therapist's approval and continued attention in treatment. The motives of the patients in these two case studies seem to have been to further their own plans by cultivating the approval and liking of their physiotherapists. This interpretation suggests that the patients recognised and were using the institutional culture of the 'good patient' to achieve their goals.

Other strategies that were used by the patients in the treatment activities interactions appeared to be implemented for self-motivational reasons to help them carry out the therapy exercises to a high standard which would help them to progress. In the CS-3 case study the patient indicated that he created his own motivation with a determined attitude towards his treatment:

"I won't give up ...because I want to be better" (CS-3 Patient interview).

The patient's determination in his therapy was also illustrated in the way he faced the discomforts of treatment:

"I will take a certain amount of pain and you've got to take pain if you're...limbering up on your limbs...you've got to go through a bit of pain to get it right...if you're stiff...there is a certain amount of pain to get those joints moving again" (CS-3 Patient interview).

This suggested that the patient had adopted the attitude that his therapy was like sports training. As this patient had previously admitted that he had been involved in training gymnastics students, it seems likely that this influenced his strong motivational approach to treatment. The patient's aims were stated as being to regain complete fitness and use of his upper limb and even these may have been symptomatic of his determined sportsmanlike outlook on his activities. The patient in the CS-4 case study also utilised a motivational strategy but his approach seemed much gentler as his intention was to help him relax during treatment activities to reduce the tension-related tone in his muscles:

"I walk differently in the [treatment] session than I do outside the session cause I'm more relaxed outside...my arm will come up in the air cause my tone will rise ...which [the therapist] explained to me ...affects my foot which affects my walking...I've got to take my mind off it that I'm not concentrating on my walking ...that is why the longer I walk up and down and hold a conversation with someone...then it'll help me relax" (CS-4 Patient interview).

It can be seen from this excerpt that the patient had some difficulties in expressing his thoughts and this may have been due to the effect of his stroke. However, the patient's conversations with the therapist during the treatment activities in the session were corroborated in the field notes and treatment session data. Whilst the patients in these two case studies may have used their motivational strategies to work hard in therapy, it is probable that they also communicated their commitment to the therapists by their actions and this may have helped them gain the therapist's approval. The data suggest that this was the intention of the CS-3 patient who seemed proud of his increased standing with the therapist on account of his gymnastics experience.

5.8 Summary

This section discussed the data from the primary and secondary case studies relating to the treatment activities interactions theme. The findings showed that the therapists utilised common verbal and physical control strategies as they worked to achieve their therapeutic assessment and patient education goals and their professional duty to maintain patient safety. The therapists were also seen to employ motivational strategies during treatment activities to encourage patient effort and compliance with treatment. The findings revealed that only four patients across the combined case studies were identified as using strategies in the treatment activities interactions to pursue goals. The patients employed various strategies in this interaction including pretence to the therapist regarding understanding of treatment, use of sports knowledge in self-motivation, concentration and control of communication. The purposes of the patients' strategies were interpreted as being focused around two main aims: to gain the therapists' attention and approval and to further progress in treatment. The meanings and significance of the participants' control strategies will be further addressed in the general discussion chapter. However, the therapists' common verbal and physical control strategies will not be dealt with in detail in this chapter as these were identified as stable interactions in the sessions and unlikely to be influenced by the power interactions between the patients and therapists.

The next chapter will present and discuss the results relating to the ‘communication interactions’ theme with reference to illustrative segments from the primary and secondary case studies.

Chapter 6 Results part two: interpretative discussion of 'communication interactions' theme

6.1 Introduction

This chapter deals with the second part of the results of the stage two study. The findings from the primary and secondary case studies relating to the 'communication interactions' theme will be presented and discussed in association with relevant excerpts from the data. The meanings of the strategic control negotiations that were used by the physiotherapists and patients in the communication interactions as they pursued their aims will be discussed to explain the significance of the communication interactions theme in relation to the developing models of strategic social interaction and partnership in stroke physiotherapy. Cross-case analysis of the combined case study data showed that all of the physiotherapists and patients controlled or used discussion as a communication strategy in the pursuit of their individual plans in the treatment sessions. The physiotherapists' purposes in this strategy were identified as: to gain information and advice; to maximise patient communication; to encourage patient and spouse's participation in treatment discussions; to persuade patient compliance; to inform, educate and explain treatment to patients; to avoid discussion of recovery. The patients were also found to use discussion to gain information but they also used it to express their views in the treatment sessions and to oppose the therapists' plans. The communication strategies of the therapists will be presented first.

6.2 Therapists' use of discussion to gain information

The data showed that four of the physiotherapists in the primary case studies and three in the secondary case studies engaged their patients in discussion in order to gain information. The fact that so many of the therapists used discussion for this purpose suggests that collecting information was an important part of their work in trying to achieve their therapeutic goals. Indeed, this may have been the case in the SCS-001, CS-2 and CS-6 case studies where the therapists were in situations which required the acquisition of essential baseline information about their patients' rehabilitation status before any further therapeutic intervention could be given. In the SCS-001 case study the field notes showed that the therapist was working with the patient in a single session only. Faced with this difficult situation the therapist explained that one of her aims was to obtain some basic information to enable her to manage the patient's treatment:

"I wanted...the baseline of the gentleman...I wanted to know how he was coping at home really" (SCS-001 Physiotherapist interview).

To obtain this vital information it appears that the therapist engaged the patient in a detailed discussion at the start of the session about his stroke and treatment to date:

"The physio had [the patient's] *notes in her hand and recapped on the events of the stroke and his rehabilitation with* [the patient]*...after much chat about rehab...the physio asked how* [the patient] *was doing now"* (SCS-001 Field notes).

From this excerpt it can be seen that the therapist made use of the patient's treatment notes in the discussion interaction and this was probably an important tool which enabled details about the patient's treatment to be clarified. The impression gained from the therapist's efforts in communicating with the patient was that she was trying to make the most of her limited opportunities in the single session to understand the patient and his main treatment issues to enable her to achieve her therapy goals. The physiotherapists in the CS-2 and CS-6 case studies also seemed to want information about their patients in their sessions even although they had worked with them before as the demographics in Table 3 in Chapter 5 confirm. According to the data these therapists experienced a break in contact with their patients and this resulted in gaps in their knowledge about recent progress and problems which had to be dealt with by implementing detailed discussions with the patients at the start of the sessions. In the CS-2 case study this was aptly illustrated by the following excerpt:

Therapist to patient: *"I haven't seen you since the end of March....* [looking at case notes] *yes you've seen* [another therapist] *for a couple of sessions...you've done some walking practice"*
Patient: *"yes"*
Therapist: *"now...you told me last time you were still keen to go home...still getting better...what's...better since I last saw you?"*
Patient: *"the last session I had last week with* [the therapist] *was a little better"* (CS-2 Treatment session transcript).

In the CS-6 case study, the following excerpt from the data illustrates the therapist's use of discussion to review the patient's progress in a separate rehabilitation group he had been attending:

Therapist to patient: *"So just tell me a little bit about how you're getting on in the* [other rehabilitation] *group"*
Patient: *"Alright...some things I can do...standing up. If I stand still me legs ache...if I'm moving I'm alright"* (CS-6 Treatment session transcript).

These data suggest that an important factor in the physiotherapists' control over the patients' treatment was information, particularly the patients' own reports of their current activities and progress. Circumstances which caused a break in the continuity of this information, such as when an unfamiliar patient had to be treated may have threatened this control. Without access to current data on the patient's activities and progress it is possible that therapeutic goals may have been difficult to plan. Other data in the case studies suggested that the therapists used discussion to try to ensure that relevant information was forthcoming from the patients. This is illustrated in the following excerpt from the CS-3 case study as the therapist conversed with the patient to encourage him to provide feedback about the pain he experienced during exercises and activities at home:

Therapist to patient: *"...had any pain in your shoulder this week?"*
Patient: *"No I had just a little clicking in the shoulder from pulling back and since then there's not been any...pain"*
Therapist: *"Really?"*
Patient: *"...it was as if something went in the socket"*
Therapist: *And you haven't had any painkillers?"*
Patient: *"No"* (CS-3 Treatment session transcript).

The field notes of the CS-4 case study showed that the physiotherapist in this session applied discussion interaction in a similar conversational way to encourage the patient and his wife to provide feedback on progress at home. In her interview, this therapist confirmed that discussion interaction with the patient was an important process in achieving control of the management of treatment and one's professional goals:

"I frequently make an effort to ask people how they find that they're getting on with their therapy because it helps guide future treatment plans and helps us work towards goals...so that we always know what we're aiming for" (CS-4 Physiotherapist interview).

The conversational discussion interactions used by the therapists in the CS-3 and CS-4 sessions were evidently important strategies to help the patients and their family members to speak freely about their experiences in treatment. These discussion strategies would have furthered the therapists' therapeutic aims because the information gained would have helped them to understand the patients' physical problems and the implications of these problems in the patients' daily lives. With these understandings the therapists would have been able to implement treatment interventions to gain some control over the patients' functional impairments. Achieving such progress may also have contributed to a sense of professional pride for the physiotherapists in their work. However, some of the data showed that not all the therapists used discussion in the same conversational manner. In the SCS-002 case study, whilst the therapist also used discussion with her patient to gather information about the patient's latest problem, this was a much shorter and less encouraging communication interaction:

"The physio then sat beside [the patient] *on the bed and asked ... about the pain in her leg. After this brief discussion* [the patient] *was asked to lie down... there was less idle conversation"* (SCS-002 Field notes).

It is possible that the therapist in this session may have believed that she had no time for relaxed discussion with the patient as she was anticipating a visit from a senior colleague whose priorities also had to be negotiated using discussion in the session:

"There was one interruption [in the session] *when the senior physio and* [the patient's] *physio were discussing the best time for the senior physio to see* [the patient]*"* (SCS-002 Field notes).

The findings suggest that the junior therapist in this session did not have full control of the progress of events as she was obliged to negotiate her time with her senior colleague and this uncertainty may have created problems for the management of effective discussion with the patient. In this respect, time may be an important factor which influences how well therapists are able to initiate discussion interactions with patients. This influence in turn may affect the information that can be gained in the discussion and the degree of power that therapists can achieve from the interaction. The data showed that the senior therapist in the SCS-002 case study also used discussion as a strategy with the junior therapist and the patient:

"Both [physiotherapists] *had a discussion about what had been tried for* [the patient's] *leg and arm. The senior therapist then took over the session. She asked* [the patient] *plenty of questions about what exercises she did at home and about her pain. The senior physio did not initiate any conversation not related to physio and seemed very confident in what she was doing"* (SCS-002 Field notes).

These data suggest that whilst the senior therapist used discussion with the junior therapist and the patient to gain information to assess the patient's therapy needs it may also have granted her control of the treatment session. The brisk confident manner which the senior therapist seemed to use in her discussions suggested that she wanted to control the session to bring it to a conclusion as quickly as possible. This act of control was probably important to the senior therapist as she tried to fulfil her professional responsibility as the junior therapist's advisor and her therapeutic goals with her own patients.

The data examined in this section suggested that gathering information about the patients and their progress through discussion interaction was an essential tool for the therapists as it enabled them to take control of treatment. The practical importance of this strategy for the therapists working with patients with unfamiliar treatment histories seemed evident as the professionals would probably not have been able to achieve much in the sessions without information. The data also showed that the therapists made the most of specialised and opportunistic sources to gain information including therapy superiors and patients' family members. The therapists seemed to have secured control of the sessions and achievement of their aims by the systematic manner in which they accessed and organised the currency of information in the sessions. The patients understanding of this process will be examined shortly with reference to their own strategic activity.

6.3 Therapists' use of discussion to support patient communication

Some of the physiotherapists were found to use periods of discussion interaction to try to support and improve their patient's communication in the treatment sessions. In these interactions it appeared that the therapists were using the opportunities presented during quiet seated periods of treatment or between treatment activities for more effective communication interaction with the patients. This may have encouraged the patients to express their views and feelings in their own way using what verbal and non-verbal communication skills they had. In the CS-5 case study where the patient was afflicted with severe expressive communication difficulties, an extended period of seated ultrasound treatment on the patient's shoulder was evidently an important opportunity for the therapist to maximise her communication interaction with the patient:

"what was nice about using a modality such as ultrasound...was that it gives you ...six or seven minutes of seated time when you...can't be rushing off round the gym, you're there with the patient for that time and that's quite a good opportunity ... to have some chat" (CS-5 Physiotherapist interview).

Effectively, it seemed that the therapist had noted the extent of the patient's communication capabilities and had identified which aspects of the treatment interactions in the session could facilitate good non-verbal communication to help the patient to express himself in his own way:

"The physiotherapist asked the patient about his home activities...whilst she applied the ultrasound gel [to the patient's shoulder]. *Good eye contact...the patient looked at the physiotherapist when she spoke to him and asked him questions...the patient smiles at the physiotherapist using a range of facial expressions, nods, eye contact when talking to each other"* (CS-5 Field notes).

In supporting the patient's communication in the session it is likely that the therapist furthered her therapeutic goals as the patient's increased communication would have provided her with essential feedback on his reactions to treatment. The therapist probably also furthered her professional goals by controlling the patient's communication as this would have facilitated the patient's participation and enabled control of the progress of the session. In a similar fashion, the therapist in the CS-1 case study was observed using frequent rest periods which occurred during treatment as opportunities to facilitate effective communication interaction with the patient about treatment:

"[the treatment] *activity is repeated then patient sits back down on wheelchair. There is then some discussion of the activity"* (CS-1 Field notes).

The patient in this case study also seemed to have difficulties in communication and understanding and it is possible that the frequent rest periods offered the best circumstances for short chats about treatment as well as enabling the patient to catch her breath. In the following example from the treatment session transcript which also involved the therapist's assistant, there is a sense that the patient benefited from being given a little time to catch her breath during a break in a treatment before she was able to join in a discussion about the activity:

Therapist to patient: *"Have a rest...that was good"*
Patient: (chuckles)
Therapist: *"That was good"*
Therapy technician to patient: *"Lift it up a bit"*
Patient: *"Oops that's that"*
Therapist to patient: *"You been doing any of those* [exercises] *at home?"*
Patient: *"No because my bed's all wrinkly"*
Therapist: *"Your bed's too soft"* (CS-1 Treatment session transcript).

In the SCS-001 case study the therapist attempted to maximise her patient's communication interaction during discussions by employing skilful non-verbal communication processes:

"Throughout...discussion the physio always sat facing [the patient] *on the bed and made eye contact whilst both listening and responding to him"* (SCS-001 Field notes).

The rationale for this strategy was probably to encourage the patient to feel that he had the therapist's full attention and that she was interested in what he had to say. As the therapist in this treatment session was only working with the patient in a one-off session it is likely that this strategy had a sound basis as establishing effective communication with the patient would have been an important factor in establishing co-operation and achieving aims.

In considering the implications of therapists' interventions to encourage patient communication in treatment, it might be said that these are positive strategies which could facilitate better patient interaction and participation. Such communication and involvement strategies may be important for therapists working with patients who have severe expressive communication difficulties who might benefit from structured participation. However, it is possible that these strategies could be construed as insidiously controlling as patient participation might be compartmentalised solely on the basis of what the therapists considered convenient or suitable.

6.4 Therapist's use of discussion to inform and educate

The data showed that some of the physiotherapists used discussion to provide information for their patients in the treatment sessions. The rationale for this was suggested in two excerpts from the SCS-007 and SCS-001 case studies which demonstrate and describe what the therapists were doing in discussion interactions with their patients:

Therapist to patient: *"the muscles that are set into your arm* [are] *inserted into your trunk and that is where the problem is with the tightness in your side and again it will have a knock on effect on your shoulder* [and] *your ability to take weight"* (SCS-007 Treatment session transcript).

"[During the discussion the therapist] *waited until* [the patient] *paused* [then went on] *to give advice on lifestyle changes or an explanation as to why his sense of touch had changed"* (SCS-001 Field notes).

From these data it is evident that the therapists employed discussion interactions as forums to explain treatment and to educate and advise patients about aspects of their treatment and home activities. There was also some evidence in the case studies that the therapists used the discussion interactions to introduce comments about the uncertainty of recovery with patients albeit in an indirect manner. However, this issue will be examined in section 6.6 with reference to a different theme. By providing information support for patients, it is likely that the therapists sought to increase their patients' understanding and participation in treatment. In considering the wider implications of the therapists' educational and advisory strategies, it is possible to see the therapist role as that of a teacher. The sharing of expert knowledge and experience with patients undergoing a process of relearning after stroke, is likely to have been a goal of the therapists even if this was not openly acknowledged in the study. Further speculation suggests however, that the therapists may also have sought to win the patients' co-operation in their work and may have ensured this by keeping them informed about what they were doing in treatment. Indeed, both these rationales might be appropriate in accordance with expected classroom etiquette under the power of the teacher.

6.5 Therapist's use of discussion for persuasion

The data from the combined case studies showed that two of the physiotherapists used discussion in their treatment sessions to try to persuade their patients to comply with treatment. The evidence seemed to suggest that the therapists in the two treatment sessions had different approaches in their use of this strategy. In the CS-6 case study the therapist used a form of nagging social banter in her interactions with the patient and this seemed to be designed to chide the patient into changing some aspect of his behaviour:

"'You are getting spoilt' said the physiotherapist [to the patient]*...the physiotherapist appeared to be smiling here but she* [also seemed to be] *making a serious point"* (CS-6 Field notes).

As the therapist explained her rationale for communicating with the patient in this way, it was shown that her aim had been to persuade the patient to drop his own plans to continue using a wheelchair and to comply with her plans to re-establish independent walking again:

"I was trying to ...jivv him along so that he will try the new things ...that I know he can do...because he does them in the physio session...it was a case of trying to persuade him to try out new things. We were talking specifically about him going into town and doing a bit more walking...because he now chooses to walk but it's very contrived...he'd much rather have his wife take the wheelchair and he doesn't need that anymore" (CS-6 Physiotherapist interview).

These excerpts from the data suggest that the therapist had a familiar long-standing working relationship with the patient in which openness and honesty of communication were accepted as normal. The demographics in Table 3 in chapter 5 show that the therapist had worked with this patient for 2 years and this long association probably sanctioned the use of a remonstrating communication strategy. The therapist's persuasion strategy seemed therefore to be exploiting the shared social understanding which had developed between the participants. This familiarity enabled the therapist to use stronger language in her interactions with the patient which emphasised the persuasive power of her communications without risk of causing offence. In the SCS-006 case study the therapist also used discussion to try to persuade the patient to defer to his plans instead of doing what she wanted:

Therapist to patient: *"You don't feel unsafe on* [the walking stick]*?"*
Patient: *"No I could get used to it"*
Therapist: *"what about outside?"*
Patient: *"no I think I'd still prefer* [to use the tripod] *when I go out"*
Therapist: *"do you want to try outside with* [the stick]*?"*
Patient: *"what now?"*
Therapist: *"no time like the present"*
Patient: *"no"*
Therapist: *"we could try it on the way back* [from the walk]
Patient: *"yes"*
Therapist: *"we'll try it on the way back"* (SCS-006 Treatment session transcript)

It can be seen from this excerpt that the therapist used persuasion in his discussion with the patient to defuse her objections to his plan to make progressive changes in her walking activity. The impression gained from these data was that the therapist had already made up his mind about what would happen and it only remained to persuade the patient to comply with this plan. In this sense the therapist did not seem interested in listening to the patient's objections but only in rebutting them to promote his own plans. Effectively, it seemed that the therapist gave the patient no room for negotiation. As the field notes recorded that this treatment session was the patient's last regular visit to the department, it is possible that the therapist's forceful persuasion of the patient to comply had some urgency about it because of the need to conclude the achievements of rehabilitation that day. Compared with the persuasion strategy used by the therapist in the CS-6 case study which used the social therapeutic relationship to exert influence, the SCS-006 therapist's strategy seemed harsher and less sympathetic. However, the SCS-006 therapist's strategy may have achieved a quicker result and this would have been viewed as advantageous by the physiotherapist if the plan was to discharge the patient that day.

The significance of these findings for the study thesis may be the implication that the therapists were sensitive to the fact that they could exert considerable persuasive influence over patients in their communication interactions. Moreover, that they could use their power to emphasise persuasive discussions by presenting them as familiar social banter or closed argument with no flexibility for negotiation. Such persuasive communications might exert a great deal of influence over patients' compliance because of trust in the therapist as the person who knows best. These issues raise several questions about the nature and suitability of therapists' use of persuasion in pursuit of treatment goals. For example, the question of the necessity of patient compliance with therapists' treatment plans. Also, the questions of how persuasive communication techniques might conflict with the principles of shared negotiation of treatment plans and therapists' professional standards of conduct. Further consideration of these questions will follow in the general discussion chapter.

6.6 Therapists' use of discussion as an avoidance strategy

The data suggested that several of the physiotherapists used their leadership power in the discussion interactions to avoid dealing with subjects they found difficult to address with patients such as progress and recovery. Superficially, the data suggested that the therapists had different justifications for acting in this way. However, it appeared that their general purpose may have been the same: to exert professional control to achieve aims that were considered more important than the provision of full information to patients. In the SCS-001 and SCS-007 case studies the therapists both acknowledged in interview that they felt unsure about discussing recovery with their patients because of their lack of in-depth knowledge about the cases:

Interviewer to therapist: *"You were saying ...that* [the patient] *still thinks he's going to recover...is it something that...should be discussed with him that maybe that's not the case?"*
Therapist: *"yeah...but it's probably a decision that I wouldn't want to make having just seen him once...I would like to treat him for a couple of weeks...to see how he responds to physio intervention"* (SCS-001 Physiotherapist interview).

Interviewer to therapist: *"Have you discussed with* [the patient] *your expectations for recovery?"*
Therapist: *"Not completely no, because she hasn't actually asked and...I've only been seeing* [the patient] *for a relatively short time..."*(SCS-007 Physiotherapist interview).

In both of these cases, the therapists were working with patients whom they did not know well and this may have made it difficult for them to predict how the patient would respond in future treatment. However, there is also a sense that the therapists' uncertainty about the patients' recovery stemmed not only from a lack of familiarity with the patient but also from a general uncertainty about what to expect in stroke recovery. To try to cope with these uncertainties, it appeared that the therapists mentioned recovery in their discussions with such vagueness so as to avoid dealing with the subject in any depth:

Therapist to patient: *"it's all because of that particular part that's responsible for feeling in the brain that was damaged in you by the stroke...now whether your brain can unscramble that or not...that remains to be seen"* (SCS-001 Treatment session transcript).

Therapist: *"I don't think* [the patient's] *going to get to 100%* [recovery] *but we haven't talked about it specifically"* (SCS-007 Physiotherapist interview).

These data suggest that the therapists felt they lacked the authority of knowledge that would have enabled them to express a professional opinion to the patients about their recovery. To have expressed an opinion without the necessary authority might have endangered the therapist's professionalism and this may have been why they sought to avoid discussing the difficult subject of recovery openly with the patients. The therapist in the SCS-002 case study seemed to be in a similar predicament. From the treatment session transcript data it did not appear that progress had been discussed with the patient in the session by either the senior or junior therapists working with the patient. When questioned for her views on the patient's recovery in interview, the junior therapist acknowledged that this had been discussed with the patient in the past to some extent. However, as she seemed to reflect upon the particular treatment session, the junior therapist showed that she was unsure about predicting recovery because of her lack of experience:

Therapist: *"we're going to ...see if she can walk a bit...I'm not sure how big a possibility it is because we've just got her standing and walking...in the* [parallel] *bars...I'm not experienced enough to...be able to make a long term judgement on just one session doing that...I'd want another two to three sessions before...I stick my neck out"* (SCS-002 Physiotherapist interview).

These data suggest that the junior physiotherapist felt she lacked the professional authority to make a decision about the patient based on her performance in the treatment session and this may have been why the issue of progress was not discussed immediately in the session. As the junior therapist had been working under the authority of a senior colleague in the session it is possible that she had been deferring the responsibility to her. However, as the senior therapist was not interviewed in the study it is not clear why she did not address the issue with the patient. It is possible that other factors such as limited availability of time in the session may have influenced the therapists in their decisions about what should be discussed with the patient. However, from the junior therapist's comments in interview it is possible to speculate that she may have been forced to sidestep open discussion of progress with the patient as it would have been unprofessional for her, because of her inexperience. In this respect, it could be said that the junior therapist's power was shaped by her understanding of her limited professional experience.

In the SCS-006 case study the observer's field notes suggested that the therapist was trying to avoid discussing issues of progress with the patient even though this was the patient's last regular treatment visit to the department before a three month break:

"The physio didn't really ask [the patient] *how she was getting on or if she had any problems or questions...although this was the last physio session* [the therapist] *didn't give* [the patient] *any advice about continuing ...exercises or any advice about the future"* (SCS-006 Field notes).

In seeking an explanation for this therapist's avoidance of communication with the patient in this final treatment session, it may be that the therapist had wanted to complete the session as quickly as possible so he could discharge the patient and fulfil his therapeutic and institutional schedules. The therapist's actions could be interpreted as being to control the compliance of the patient as this would have given him complete control in the session. However, by controlling the patient's compliance the therapist would also have constrained the patient's right to use session time to question the therapist for advice or reassurance. It is possible that this could have implications for patients' emotional adjustment to the discharge event and their feeling of control in leaving the support of treatment.

6.7 Patient's use of discussion to express views

The combined case study data showed that most of the patients used the discussion interactions as a means to express their views and experiences of the stroke to the therapists. However, depending upon their communication abilities and what they wanted to express, it appeared that the patients had to use different strategies to achieve this. Many patients seemed able to express their views and feelings in words as in this example from the SCS-002 case study:

Patient to therapist 1: *"I've been standing up"*
Therapist 1 *"Oh I don't think that's a good idea"*
Patient: *"Well I've got to straighten* [the leg]*"*
Therapist 1: *"Yes I know but if we can't do it here then it's not a...good idea for you to do it at home"*(SCS-002 Treatment session transcript)

In this interaction, as the case study summaries in chapter 5 confirm, the patient was communicating with the junior therapist 1 who was her regular therapist in treatment. The interaction took place before the senior physiotherapist arrived on the scene. The excerpt showed that the patient was able to express her own opinions quite freely when she wanted to, even when the therapist was unhappy about her disclosure. Indeed, the patient seemed quite assertive in her expression of what she thought she should be doing at home. In the patient's interactions with the less familiar senior therapist 2, she did not appear to be as assertive in the discussions however, as the data showed she was still able to express her views openly when invited to do so:

Therapist 2 to patient: *"can you put your weight on your right leg?"*
Patient: *"No I can try to but what I've started doing recently I've got a bar in my toilet and when I pull up I can try to stand...and put some weight"* (SCS-002 Treatment session transcript).

This patient's aims were recorded as being to walk again and to regain the ability to do what she wished in life. This suggests that the patient was keen to regain her own decision-making power again. In this respect, it is perhaps not surprising that the patient took the trouble to assert herself in treatment and to express her views to familiar and unfamiliar therapy staff alike. Doing so may have given her a feeling of being in control again. In another case study (CS-2), the patient was described by the therapist in her interview as being reticent about communicating her views in treatment:

Therapist: *"there's a challenge in...communicating and trying to...get her to express exactly what she wants and why she thinks...it'll work out the way she's expecting"* (CS-2 Physiotherapist interview).

However, as the treatment session data showed, the patient could express herself when she wanted her opinion of treatment to be heard:

Therapist to patient: *"do you need to have a stand during the day a bit more frequently?"*

Patient: *"I don't know that standing just standing would make any difference...it's movement as well...no matter how...you try to exercise...sitting it...doesn't work as satisfactorily as being able to walk"* (CS-2 Treatment session transcript).

There is a sense from the two excerpts above that the patient's aims were not in accord with the therapist's plans and that there was conflict of understanding which influenced the way that the participants communicated with each other about treatment. According to the case study summaries in chapter 5, the patient's aims were to be able to walk again and to go home to live alone. The therapist's aims however were more concerned with ensuring the patient's safety by concentrating on helping her to stand and transfer to and from her chair. The evidence shows that the patient was able to express her wishes quite clearly when she felt this was important, despite the therapist's belief that she was not capable of doing this. However, as the therapist's comment in the above excerpt shows the patient could also be very reticent about sharing her views. This seemed to create problems for the therapist as it evidently prevented shared discussion about treatment and expected outcomes. It is possible that the patient was reticent about coming into conflict with the therapist about her aims and this was why she tended to say little openly about her plans in treatment. Following this reasoning it seems likely that the patient may have controlled her participation in the discussion interactions to maintain her hopes of eventually gaining the independence and homecoming she wanted. This would have minimised her exposure to the therapist's arguments against her plans on the grounds of safety which might have shattered the patient's control over her hopes.

In contrast, the patient in the SCS-001 case study seemed to derive some comfort from discussing his stroke experience with the therapist, perhaps to assuage his feelings of regret about how it had affected his life:

"During the conversation about golf [the patient] *mentioned that he was having such a good life before he had the stroke"* (SCS-001 Field notes).

The patient's sad comment above suggests that he may have been depressed about the change that the stroke had visited on his previously happy life. As the patient talked over his feelings with the therapist it is possible that this may have helped him to develop a different perspective of the event and its problems and this may have increased his sense of control over the stroke. In the SCS-007 case study, the patient seemed to have a more relaxed approach to her stroke but she too may have gained some emotional and psychological support from her discussion interactions with the therapist:

"[The patient] *asked questions and seemed comfortable doing so....throughout the* [treatment] *session the two talked...together...I felt that the physio...was a great source of encouragement and motivation for* [the patient]*"* (SCS-007 Field notes).

As with the patient in the SCS-001 case, the personal support which this patient could access through discussion interaction with the therapist may have helped her to regain control over the stroke. It seems evident from these data that the patient's engaging with the therapist in discussion provided them with an outlet in which their concerns could be addressed openly with someone who had the expertise to reassure or advise them. This too may have helped the patient's to take control and may have encouraged the development of shared understanding between therapist and patient of the stroke, its problems and the course of rehabilitation. Other data showed that communication difficulties with some patients may have constrained their discussion interactions with the therapists but some effort was still made to say what they wanted using different communication methods in the sessions. In the CS-1 case study, the patient suggested that discussion interaction with the therapist was easier when sitting rather than lying down during treatment:

Patient: "[it] *is easier to talk to* [the therapist] *...on a chair than it is to talk to him when you're laid down"* (CS-1 Patient interview).

As the field notes of this session show that part of the patient's treatment was conducted with her lying on a bench, it is possible that she felt less in control of herself during supine treatments and at a disadvantage in being able to interact on a social level of communication with eye contact for example. However, it is also possible that the patient was suggesting that during supine treatments, communication was not expected or welcomed by the therapists, who wanted to concentrate on therapy goals. In the CS-5 and CS-6 case studies however, the patients resorted to non-verbal methods to communicate their views to the therapists and this may have been an effective way of letting the therapists know their feelings without having to wait for permission. In the CS-5 session, the patient had severe expressive communication difficulties and this entailed his using a variety of non-verbal communication tools, including facial expressions and pointing to express his feelings to the therapist:

"Patient used [his unaffected] *left hand to touch* [his] *shoulder which was clearly sore...patient smiles at* [the therapist] *using a range of facial expressions, nods"* (CS-5 Field notes).

According to the field notes, these non-verbal communication strategies took place whilst the patient and the therapist were going through a seated ultrasound treatment. In this position, it is likely to have been easy for the patient to express himself using facial expressions. However, during more active elements of treatment when good eye contact may not have been possible, the patient used other forms of expression including sounds to communicate effort and pain to the therapist:

Therapist to patient: *"just going to put you on a bit of a stretch now"*
Patient: *"heh" (short quick exhalation)*
Therapist: *"alright?"*
Patient: *"yeah"*
(pause in sounds)
Patient: *"oh" (as if in discomfort)*
Therapist: *"you alright can you bear with it for just a minute?"*(CS-5 Treatment session transcript)

The patient's use of whatever verbal and non-verbal means he could to express his feelings suggests that it was an important aim for him to make himself understood in the session. The excerpt above illustrates that this strategy was evidently effective in gaining the attention of the therapist because she was concerned for his comfort. Gaining the therapist's attention was not expressed by the patient as one of his aims in the session. However, it is possible that the patient understood that keeping the physiotherapist informed of how he was feeling during treatment was something important he could do and something that the therapist might want. The patient's actions could therefore be defined as being respectful of the therapist's plans. In a similar fashion the patient in the CS-6 case study used some verbal exclamations and emotive sounds to express effort, pain and fatigue:

Therapist to patient: *"and back again"*
Patient: *(breath in and exhalation sounds)*
Therapist: *"and this one"*
Patient: *"oooh this is a problem"*(CS-6 Treatment session transcript)

From the field notes it can be seen that the patient experienced a good deal of discomfort during a vigorous standing activity and because of this it is likely that his expressions were intended to communicate his hardship to the therapist in the hope that she might ease up a little or allow him to rest:

"As the patient stood he looked red in the face [with his] *mouth firm and breathing hard, concentrating on doing* [the] *activity. He puffed as he sat down"* (CS-6 Field notes).

As two of the patient's aims were stated as being to walk normally and to improve the working of his leg it is possible that he was trying to go along with the therapist's orders in the hope that this would help him achieve his aims. However, the patient's show of effort might also have been an important strategy to gain the therapist's approval because this would have maintained the long-standing working relationship that the participants had developed between them.

Considering the evidence in this section, it appears that through discussion interactions patients could gain access to the therapist's support and information and this could help patients to accept and take greater control over their stroke and its consequences in their lives. It might also encourage patients to become more active participants in treatment and support more effective non-verbal communication and shared understanding between therapists and patients. The data presented showed that patients were evidently prepared to push themselves forward to use these communication opportunities to achieve what was important to them, despite communication problems and social reticence. This determination suggests that patients possessed some awareness of the social power relations in their treatment and a sense of their own authority in being able to make things happen through communication. Whilst the discussions were probably under the control of the physiotherapists in the sessions, it seems likely that these interactions offered a viable interface for communication and negotiation of sanctioned participation between the therapists and patients.

6.8 Patient's use of discussion to oppose therapist plans

The data showed that two of the patients in the case studies were faced with changes in their treatment that they disagreed with and that they reacted by employing argumentative and pleading techniques in the discussion interactions to try to persuade the therapists to leave treatment as it was and to let them do what they wanted. In the first of these two case studies, the CS-6 case, the patient was seen trying to use argument about his problems to try to prevent the therapist from removing his wheelchair from him to encourage more independence in walking:

Therapist to patient: *"You may have to do the really long distances in the* [wheel]*chair but then you get out and you walk"*
Patient: *"I can't see* [me] *going down the town with* [my wife]*...without my* [wheel]*chair how am I gonna walk around with her cause I ain't gonna be able to walk that far...with me sticks"* (CS-6 Treatment session transcript).

From this data it can be seen that the patient could only see problems in his path if he lost the use of his wheelchair and this suggests that he felt he would lose an element of control over his life if he was forced to use his sticks as the therapist wanted. The patient confirmed this assumption in interview as he revealed how he felt about his walking problems and the difficulties he faced trying to walk normally:

Patient: *"I said to* [the therapist] *I walk in the house without sticks like a ducky fashion flip flop...I go around on me sticks but I can't walk far"* (CS-6 Patient interview).

There is a sense here that the patient may have been embarrassed about his abnormal gait since the stroke and his inability to walk properly with sticks. This suggests that the patient's persuasive argument against the therapist's plans was being used to save face as he evidently felt unhappy about going out in public places with his present ungainly and unreliable mobility. The patient's embarrassment may have lent strength to his resolve to try to control the therapist's plans. The excerpt from the treatment session transcript also showed that the therapist was determined to make the patient comply with what she wanted and this may have been why the patient chose to use a directly oppositional approach to try to achieve his own plans. In the SCS-006 case study the field notes record that the patient used a pleading approach to try to persuade the therapist to let her continue with a familiar walking aid rather than use a stick:

"The physio...said he would like to try [the patient] *on a stick instead of the tripod she had....*[the patient] *tried out the stick but pleaded with the physio not to take away the tripod"* (SCS-006 Field notes).

These data suggest that the SCS-006 patient rather than feeling embarrassed about her walking, may have been forced to oppose the therapist's plans for change because she was afraid of something. The patient's interview data suggests that this was a fear of falling and as the patient had evidently fallen already, it is likely that she perceived the therapist's insistence that she use a stick to walk as a threat to her wellbeing and confidence:

Patient: *"the pavements are so uneven ...and where I fell before I'm frightened"* (SCS-006 Patient Interview).

The patient's use of this strategy is similar to that used by the patient in the CS-6 case study in that both were evidently trying to maintain a sense of control over their lives which the therapist's plans threatened to upset. The impression gained from these data was that the patients' actions were not planned strategies, but rather defensive measures to try to hold onto something that the therapists wanted them to change. This suggests that the patients' strategies were immediate tactical responses rather than pre-meditated strategic acts in the treatment interactions. If we consider persuasive discussion as a negotiation strategy, then it seems that the patients' pleading arguments gave them little advantage because they were passive emotive reactions with little persuasive power over the therapists' reasoned treatment plans.

Further consideration of the CS-6 case data suggested that the patient may have argued with the therapist as a show of token resistance only whilst still upholding the value of the therapist's plans as a means to his achieving recovery. In this respect, it appeared that the patient was playing out a role in his interaction with the therapist, perhaps as devil's advocate in answer to her provocative banter. The impression gained was that this competitive interaction had been negotiated between them as a sequel to the over-familiar working relationship which had developed over the 2 years they had worked together in the patient's rehabilitation.

6.9 Patient and spouse's use of discussion to gain information

The data showed that some of the patients and one of their spouses used discussion to gain information from the therapists that was important to them. The way in which this was done in the individual cases suggested that the patients and the spouse had tried to show the therapists that they had status beyond that of being 'patients' or 'relatives' in order to be granted the information they desired. This was demonstrated in the CS-1 case study as the patient persistently talked to the therapist and his assistant about the date of her next treatment visit:

Patient to therapy assistant: *"You don't know when I come again?"*
Therapy assistant: *"well we're shut next week for moving* [to another location]
Therapist: *"The following Monday"*
Patient: *"I'm in on Monday...the following Monday"*
Therapist: *"It'll be the...two weeks from now...Thursday two weeks from now"*
Patient: *"Could come on the Tuesday"*
Therapist: *"Well...we'll have a sit down and have a talk about what...might work because you've been a bit broken up recently"* (CS-1 Treatment session transcript).

The above except is a condensed part of the interaction from the treatment session which extended over seven pages in the session transcript. The patient's evident persistence in trying to get a firm decision from the therapist about her next appointment suggests that this was important to her and that she was keen to return. As the patient's stated aim in treatment was to do her best in accordance with the therapist's plans, it is possible that she was trying to prove her determination and keenness to him by pursuing her treatment appointment. The patient's actions suggest that she was negotiating with the therapist by showing that she was a good patient, keen to get on in treatment. In return the patient may have hoped to encourage the therapy staff's continued sympathy and expert help. In the CS-3 case study the patient used discussion and physical demonstration to show the therapist the innovative exercises he was doing at home and the purpose of this may have been similar to the CS-1 patient's plans:

Patient: *" I sometimes try things different and then I go to* [the therapist] *and* [say] *...I've tried doing so and so and she said...no don't do that...but sometimes when I say I'm doing so and so she'll say ...yes keep that one up...but there's not been many times that she's said don't do it. Every movement I do is advancing myself...I relate to her everything I do just in case I'm wrong...and she would in no doubt put me right"* (CS-3 Patient interview).

The patient suggested here that he did this in order to gain the therapist's reassurance that he was doing nothing wrong in his exercises and to gain her advice on how he could improve his work. However, there is also a sense that the patient was communicating to the therapist that he was an excellent patient and one who was prepared to work hard and on his own initiative to achieve progress. Through this negotiation of his virtues the patient may have hoped to gain the therapist's liking and attention in treatment with which he could progress closer towards his goal of regaining his fitness. Interestingly, some of the data suggested that patients' spouses were able to use similar negotiations to convince the therapists that they were worthy of attention and information. This was shown in the CS-4 case study as the patient's wife engaged in discussion with the therapist about home exercises she was helping him with:

"[the therapist]*...looked at the patient during a discussion interaction about* [his activities]. *Wife took control showing and saying what she...had been doing with* [her husband in] *a particular home activity...*[the therapist] *looked at* [the patient's] *wife and they talked...*[the therapist] *suggested 'lets have a look at this'"* (CS-4 Field notes).

Evidently the patient's wife was seeking reassurance and advice from the therapist regarding her husband's home exercises which she was involved in helping with. However, the way in which she took control of the discussion and communicated confidently with the therapist about her involvement in her husband's treatment suggested that she was acting as one of the therapist's colleagues rather than the patient's wife. The case study summaries in chapter 5 note that the aims of the patient's wife had been to find out more about her husband's home exercise programme and to act as an advocate for him in the session. To achieve these goals, it appeared that the patient's wife stepped outside the role of the relative and negotiated with the therapist to be recognised as a practising member of the patient's rehabilitation team. By gaining this recognition, the patient's wife may have gained the therapist's attention more than she would have done as the patient's wife because relatives may not usually be perceived as being active participants in treatment.

These data suggest that the information-seeking strategies of the patients and the spouse were quite sophisticated as they required negotiation to prove determination or status with the therapists to encourage them to impart their knowledge freely. This alteration in status for the patients and the spouse may have been temporary and not presumptive of any expertise in the sessions. However, the strategies appeared nonetheless to be assertions of the individuals' own power in the sessions as they pursued the goals they wanted to achieve for themselves or their loved ones. It also suggests that patients and their families may be aware of the power of status in the professional world and how this insight could be used as a negotiation tool to exert influence over the professional.

6.10 Summary

This chapter discussed the data from the combined case studies relating to the communication interactions theme. The results showed that communication strategies were important to therapists as they were a means to gain information about patients which was necessary to manage treatment. Communication strategies were also seen to be important tools to enable therapists to control patients as they used them to support patients' communication, to inform and educate them and to persuade them to comply with the chosen treatment. The therapists also appeared to use communication as a strategy to cope with the difficult problem of discussing recovery with patients, particularly in situations where they lacked full knowledge about the patient. Many of these strategies showed that discussion could be used effectively as an inclusive tool to encourage patient participation in treatment. However, some of the strategies which were used suggested that therapists were vulnerable to losing control in sessions if they lacked information and this led them to use more coercive strategies to manage their interactions with patients to achieve their professional goals. The achievement of professional goals appeared to be considered a priority over the patient's need for information.

The findings also showed that patients used communication strategies in their own ways to express their views in treatment, to gain information and to oppose the therapist's plans. These strategies showed that patients and their spouses could assert themselves in communication interactions using verbal and non-verbal techniques to influence the therapists to gain information and reassurance. However, as the patients tried to oppose the therapists' plans they seemed to resort to more reactive techniques to plead their causes with more powerful professionals. These points will be discussed in more detail in the general discussion chapter 8.

Chapter 7 Results part three: interpretative discussion of social interactions theme

7.1 Introduction

This chapter deals with the third part of the results of the stage two study. In conjunction with key extracts from the combined case study data, the chapter will present an interpretative discussion of the findings relating to the social interactions theme. This will involve discussion of the meanings of the strategic control negotiations that were employed by the physiotherapists and patients in the social interactions. The significance of these meanings for the understanding of the strategic use of power in stroke physiotherapy treatment and its implications for partnership will also be discussed. Cross-case analysis of the data from the case studies showed that the therapists used the social interaction they had with patients to achieve goals that furthered their advantage in their therapeutic work. These goals were interpreted as: to gain information; to encourage social communication with the patient; to increase therapists' professional control of treatment. Analysis of the data also showed that the patients used social interaction as a strategy to try to achieve what they wanted in the treatment sessions. The patients' aims in using social interaction seemed to be to gain social support from people in the treatment setting; to gain therapists' sympathy and professional attention; to safeguard control in their social life. The chapter will deal with the therapist social strategies first.

7.2 Therapists' use of social interaction to gain information

The data showed that a few of the therapists used elements of social interaction in the treatment sessions as means to collect information which could be used to increase their understanding of the patients. In the CS-1 case study the therapist suggested that he had made use of the therapy assistant's longer association with the patient and the day hospital as a source of information:

Therapist: *"the [therapy] assistant has been here for quite a long time...and she's very very useful at...helping out with...certain details of what we're working on because of familiarity"* (CS-1 Physiotherapist interview).

According to the demographics in tables 3 and 4 in chapter 5, the CS-1 patient had been receiving treatment in the day hospital for 17 months and this therapist had only been involved for 3 months of this time. It is to be supposed that the therapist's lack of knowledge about the patient's previous experiences in the day hospital may potentially have threatened his control over his goals and the patient in the present treatment session. However, the therapist's identification of the assistant's long-standing interaction with the patient in treatment as a social resource may have helped to ensure that this problem did not arise. In the CS-4 and CS-5 case studies the therapists also used social interaction as a tool to gain information from the patients but in a different fashion. As the data showed, the therapists in these two cases used social chat with the patients as a means to find out about their social lives and their family interactions. This is illustrated in the following excerpts from the data of the two case studies:

Therapist: *"I've known this gentleman for some time now...I've got to know his wife she's come in every treatment session....some of his children have been in ...there is often a lot of time...in therapy...that you may be quiet...and often those times it is nice to find out how they're getting on....so that...means a bit more to you really"* (CS-4 Physiotherapist interview).

Therapist: *"Have you been out?"*
Patient: *"Mum has had a...cold"*
Therapist: *"so she's had a cold"*
Patient: *"yeh"*
Therapist: *"I'm assuming she's not...all that great then this week is she?"*
Patient: *"No no"*
Therapist: *"not felt like venturing far perhaps"* (CS-5 Treatment session transcript)

These data suggest that the therapists implemented periods of social interaction with the patients because they wanted to assess the status of their family support networks to ensure that there were no problems. This information would have enabled the therapists to understand the patients and their social circumstances better. It may also have enabled them to control the two patients' rehabilitation at home as any difficulties with family might have influenced the patients' abilities to continue with their treatment at home. On the surface there seemed to be some similarity between the therapists' use of social interaction to gain information from the patients and their use of more formal discussion interaction for the same purpose which was examined in chapter 6. Perhaps this is to be expected since human communication whether formal or informal is based on similar social underpinnings. An appraisal of the differential definitions of the social and discussion interaction structures in the data at this stage in the analysis may help to clarify the distinct meanings of these themes.

The social interactions have been identified as episodes or references of humorous or personal interaction and communication. The discussion interactions have been identified as episodes of verbal and non-verbal communication with no overt personal or humorous interaction or content. As the excerpts discussed above from the CS-4 and CS-5 case studies show that the therapists obtained social information concerning the patients' family and personal home life, then it seems evident that these were social interaction strategies. The data discussed in this section suggested that the therapists appropriated social interactions in treatment for therapeutic rather than social ends. The therapists therefore appeared to have very different understandings of the purpose of social interactions in treatment from those of the patients. To the therapists the social interactions seem to have been defined on the basis of the opportunities they presented for social power manipulation to achieve goals in therapy rather than as interludes for friendly social discourse.

7.3 Therapists' use of social interaction to encourage social communication

In contrast to the information-seeking social behaviour discussed above, the data showed that several of the therapists used social interactions with the general intention of encouraging patients to take a more active social role in treatment. Within this broad purpose, it appeared that the therapists had individual rationales for trying to induce their patients to be more socially communicative and to use different strategies to achieve this. In the CS-2 case study the therapist occasionally expressed humorous self-deprecating comments and this seemed to be designed to counteract the patient's serious nature which persisted throughout the treatment session:

Therapist to patient: *"I think we both deserve a cup of coffee after that...did you get one when you arrived this morning?"*
Patient: "*Yes*"
Therapist: *"I have to make my own"*
Patient: *"Ahh"*
Therapist: "*Tough life*"

It is likely that the patient's serious manner may have made communication difficult for the therapist during the session. In this respect, it is possible that as she tried to draw the patient into social interaction the therapist may have been hoping to get the patient to relax and to communicate more freely in general. The therapist in the SCS-001 case study may have had similar intentions in her use of social humour about a problem she had with her voice at the start of the single session she had with the patient:

Therapist to patient: *"I think you'd better treat me because I'm not that good at talking"* Patient: *"Oh dear"* (SCS-001 Treatment session transcript)

It is possible that the therapist opened the session with this humorous quip about her voice problem in order to establish an immediate social connection with the patient who might have been expected to offer sympathy to her. Indeed, the observer's field notes show that the therapist was successful in communicating socially with the patient early in the session:

"A rapport was built up immediately between [the patient] and the physio" (SCS-001 Field notes).

The therapist's purpose in establishing an early social rapport with the patient may have been of vital importance in this one-off treatment session because it would have opened a channel of communication that could be used to meet therapy goals. It may also have secured the patient's liking and trust and these may have been significant social factors in the development of co-operation and compliance with treatment. Essentially, it could be said that the therapist's social humour had been used to break down social barriers of unfamiliarity which may have constrained communication if they had been allowed to remain intact. In the SCS-007 case study the therapist seemed to have overcome the problem of social barriers to effective interaction with the patient after several weeks of working together and building an understanding relationship:

Therapist: *"I've...been seeing* [the patient] *for six weeks...it takes a few weeks to get to know* [the patient] *anyway"* (SCS-007 Physiotherapist interview).

The field notes confirmed that a friendly social rapport had already been established between the therapist and the patient as the interaction in the session was easy and familiar:

"When the physio session first started there seemed to be an immediate rapport between the physio and [the patient]. They laughed and joked together with what seemed to be a great deal of familiarity. All throughout the session the two talked and laughed together" (SCS-007 Field notes).

The impression gained from these data was that the therapist had sought to maintain friendly social interaction with the patient to ensure that an effective level of communication continued in their work together. The open and friendly social interaction evident in the field notes suggests that the therapist had gained the patient's liking and trust. From the therapist's perspective, this may have been an advantageous social circumstance as it could induce co-operative interaction which would assist in the completion of therapeutic work in the session.

In the CS-4 case study the therapist took a different approach to managing social relations with the patient. In this case study the therapist suggested that therapeutic touch could be used to remove barriers which hindered social communication as this social contact was perhaps reassuring and comforting to patients during treatment:

Therapist: *"by putting your hands around the hip joint...you can actually increase the feeling of stability...very often...patients can achieve something here with hands on facilitation that they may not be able to do at home because they haven't been given that stability...people like to be touched...it's a nice way of breaking down barriers"* (CS-4 Physiotherapist interview).

The demographics in chapter 5, tables 3 and 4 show that the CS-4 therapist and patient had been working together for a period of eight months and so it is unlikely that social barriers were a particular problem in their interactions in the observed treatment session. However, it is possible that the therapist may have been speaking generally and not specifically about her interaction with the CS-4 patient in this comment. The data nonetheless provide an interesting insight into the therapist's perception that the tactile therapeutic processes could be used as social strategies to encourage positive social interactions with patients. Evidently, the therapist in this case study believed that patients enjoyed the reassurance that therapeutic touch gave them during treatment and that this may have helped to establish trusting working relations. This may have been a useful understanding for the therapist's sense of control in the session as reassured patients may be more relaxed and likely to comply with treatment. However, as the patient in the CS-2 case study suggested in her interview, physical proximity and contact during treatment might also be interpreted as an imposition on the patient's independence:

Researcher to patient: *"Does* [the therapist's closeness during standing transfers]*...reassure you?"*
Patient: *"Oh it reassures...but makes you feel...more inadequate...having so much...help"* (CS-2 Patient interview).

These data highlight the risk of misunderstandings occurring in the social interactions between therapists and patients in stroke physiotherapy which may be further exacerbated by differences in age and gender. Thus, an elderly patient may not understand humour or touch in the same way as a younger therapist might. The different social models of behaviour that therapists and patients constructed may be expected to influence the social power they had to control events in their interactions in treatment. The evidence from the case studies relating to the patients' perception and use of the social elements of treatment will be examined later in this chapter and may help to illuminate this issue more clearly.

7.4 Therapists' use of social interaction to increase professional control

Some of the data suggested that the therapists employed aspects of the social interactions to try to further their professional control over the patients in the treatment sessions. The therapists' actions seemed to be based upon the need to control aspects of patient behaviour which were deemed inappropriate during treatment because they threatened the therapists' institutional goals and their professional integrity. This was illustrated in the CS-3 case study as the therapist used a chiding comment to manage the patient's humorous activity which may have been a little out of place at that point in the session as she was trying to gain information from the patient:

Therapist to patient: *"How are your feet (laughs)...ah you cheeky (laughs)"*
Patient: *"Okay"* (CS-3 Treatment session transcript).

It is interesting to note that the therapist seemed to chide the patient whilst continuing to maintain the light-hearted social theme in the interaction. It is possible that she recognised that humour was an important part of her interaction with the patient but that this had to be controlled to ensure that it did not obscure her leadership of the session and her therapeutic goals. Indeed, the field notes record the impression that the therapist understood the patient's humour and managed it deftly with brisk humorous responses of her own:

"The therapist did seem...to be aware of the patient's rather bashful response to her as he used humour...however whilst she smiled and laughed at this occasionally, she kept the mood purposeful and focused" (CS-3 Field notes).

The therapist's gently chiding response to the patient's inappropriate humour suggests that she was sensitive to the need to maintain the positive social mood and friendly working relations with the patient even whilst she reasserted her professional authority in the session. This social sensitivity may have been an important part of the therapist's strategic control in her interactions with the patient. In the SCS-001 case study the therapist also demonstrated sensitivity to the social aspects of the treatment session. In this case, the therapist seemed concerned about the patient's social gossip becoming too personal and inappropriate in a session that was being audio-taped as she curbed it with a gentle warning:

Patient to therapist: *"do you know* [person's name]*?"*
Therapist: *"yeah I know her how is she?"*
Patient: *"oh yeah"*
Therapist: *"I'm not saying anything on tape"*
Patient: *"oh the things they say down there"*
Therapist: *"careful you're on the tape"* (SCS-001 Treatment session transcript)

The therapist's goal in this interaction seemed to be to curtail the patient's social interaction with her because she was aware that social gossip may have compromised her professionalism in the session. This situation in association with the previous therapist's social control strategy illustrates the dilemma that therapists seem to face in trying to encourage good social working relations with patients without this developing into inappropriate over-familiarity. The social strategies used by these two therapists may have been designed to establish a benchmark of appropriate social behaviour with the patients without creating too much of a social distance. In this way, the positive social working relationship could be sustained without the therapists' professional authority or standards being compromised. Whilst the therapists in the CS-3 and SCS-001 case studies seemed to use sensitively controlling social strategies to manage the social behaviour of the patients under their care, the data showed that other therapists resorted to strategies of social avoidance to control their patients' social activities. In the SCS-002 case study, the patient was assessed by a visiting senior therapist and the field notes suggested that this person adopted a treatment-focused attitude to the patient which seemed to avoid any overt friendly social communication:

"The senior physio...did not initiate any conversation not related to physio" (SCS-002 Field notes).

The senior therapist's purpose in avoiding social interaction with the patient in this session may have related to the fact that she was only working with the patient in a brief consultation session and that she had her own patient to attend to as the case study summary in chapter 5 and the field notes record. As the senior therapist had several demands on her time it is probable that avoiding social interaction with the patient helped her to control the duration of the consultation and this enabled her to manage all of her responsibilities. In the SCS-006 and SCS-007 case studies, the therapists seemed also to utilise social avoidance strategies but these were implemented to facilitate reduction or severance of the patients' dependence on therapy. In the SCS-007 case study the data showed that the therapist sought to use a social severance strategy in the form of a temporary break from therapy for two months to encourage the patient to become less socially dependent on this service:

Therapist: *"I would consider giving* [the patient] *a break in four months time probably...giving her two months off and then seeing her intensively again for six weeks...*[patients] *become quite dependant, it becomes part of their routine coming into the hospital twice a week...it makes the treatment more healthy, not totally taking over, its part of their everyday life"* (SCS-007 Physiotherapist interview).

In the SCS-006 case study the observer's field notes record how the therapist adopted a detached social manner with the patient in what was the patient's last regular treatment session in the day hospital and this may have been evidence of a social severance strategy:

"The physio didn't really ask [the patient] how she was getting on or if she had any problems or questions...although this was the last physio session [the therapist] *didn't give...any advice about the future...although there was some conversation, the physio looked at the ground for the most part...there were many silences during the session and I felt that neither* [the patient] *nor the physio were at ease"* (SCS-006 Field notes).

These data suggest that the therapist wanted to conclude the discharge treatment session promptly and to avoid any social communication that might hinder progress towards this goal. In this respect, perhaps the therapist's unsociability was designed to discourage any objections from the patient who would otherwise be expected to comply with the discharge plan. However, there is also the sense that the therapist was avoiding social interaction because he felt uncomfortable or unable to communicate with the patient about on-going plans for her rehabilitation perhaps because these were uncertain. The field notes seemed to support this supposition as they revealed that the therapist tentatively informed the patient about a future review visit to the day hospital after discharge and seemed keen to avoid showing any concern about the patient's reaction to the matter:

"[the therapist] *mentioned that there may be a review where* [the patient] *would come back to the day hospital to be seen by the team.* [The patient] *was surprised by this as she had not been told about it before.* [The patient] *commented that she thought she was being thrown out to the wolves. The physio's response to this was no not entirely. I don't feel that this entirely reassured* [the patient] *as* [the therapist] *was not sure when the...review was"* (SCS-006 Field notes).

These excerpts from the SCS-006 and SCS-007 cases seem to suggest that the therapists felt that patients regarded therapy as a social support network and that this was a problem which had to be controlled. Discouraging the patients from relying too closely on therapy for social support may have been important for the therapists who probably had expectations of patients' eventual discharge from treatment in accordance with therapeutic and institutional plans. In this respect, it is possible that initiating social severance strategies prior to or at the point of discharge may have helped the therapists to meet their responsibilities. It is interesting to note that the therapist in the SCS-007 case study anticipated that the patient might become distressed at being discharged from regular treatment and asserted that a small deception would be necessary to encourage acceptance and compliance:

Therapist: *"you'd have to explain very carefully to [the patient] why you're having a break of treatment and you would have to time it and maybe coincide it with her having a holiday...so it's actually a natural break and then restart her again"* (SCS-007 Physiotherapist interview)

These strategies of social detachment seemed to be important to the therapists to enable them to achieve their therapeutic, professional and institutional goals as the patients were evidently considered unreliable in being able to accept that therapy could not continue indefinitely. These strategies in conjunction with the other social control strategies discussed earlier seemed to be aimed at suppressing patients' natural social interactions for the purposes of maintaining progress in the sessions and with treatment goals and sustaining the therapists' professional status. The therapists' conceptualisation of social interaction as a problem in certain circumstances in relation to their pursuit of therapeutic, professional and institutional goals could be interpreted as a denial of the social dynamics of their work. Therapeutic interaction taking place under the necessity of social control strategies to meet the demands of therapists' diverse goals must therefore have implications for the development of partnership working. This question will be considered in more detail in the general discussion chapter 8 after examination of the patients' understandings and uses of social strategies in the treatment sessions.

7.5 Patients' use of social interaction to gain attention and help

Analysis of the data across the combined case studies revealed that the patients used social interaction to gain therapeutic attention, social sympathy and help from the therapists and social support from others in the day hospital. This suggested that social support was an important part of therapy for patients generally. Let us examine the specific evidence in each case to understand why this meant so much to the patients, how they sought this support and the implications this had for their working relations with the therapists. The patient in the CS-1 case study showed that she believed the therapist to be a friend and approachable confidante this may have been an important factor that led her to seek to gain his attention and sympathy in treatment:

Patient: "[the therapist is] *not like a...person you go in fear of...he* [is] *more of a friend you know...he'll talk to you and he'll listen to you"* (CS-1 Patient interview).

This excerpt suggests that the patient wanted someone she could rely on for information and a friendly ear during treatment. Perhaps in pursuit of this aim the patient used endearing behaviour in her interactions with the therapist and therapy assistant and as the excerpt showed, this seemed to encourage positive helping responses from the therapy staff working with her:

"Patient smiles a lot and chuckles when she says anything to the therapist or [therapy assistant]. [Therapy assistant] *responds to this more than the therapist"* (CS-1 Field notes).

It is interesting to note that the therapist seemed to be less influenced by the patient's social endearment behaviour than the therapy assistant was. However, as the data in section 7.1 suggested that the patient had a long-standing working relationship with the therapy assistant it is perhaps not surprising that her social interactions with this individual were more effective than those with the therapist. The data showed that the patient in the CS-3 case study also employed social endearment to encourage the therapist's sympathy, attention and help. In this case the patient seemed to express shy reverence of the therapist and her treatment in his bashful humorous comments and this gained him the therapist's good humour and firm advice:

Therapist: *"Okay just relax the shoulder there"*
(long pause as the therapist worked with the patient's shoulder)
Patient: *"You'll have to come with me every day"*
Therapist: (long laugh)

Patient: (laughs)
Therapist: *"No I want you to continue doing exactly what you're doing at home"*
Patient: "yes" (CS-3 Treatment session transcript)

The patient's social endearment strategy seemed from this excerpt to be effective in gaining the therapist's liking, social support and therapeutic attention. In the case study summary in chapter 5, the CS-3 patient's goals suggested that he was quite determined to achieve full recovery and it is possible that the patient used the social interactions in a calculating manner to gain the therapist's attention in pursuit of this goal. However, the excerpt above suggests that the patient also gained some enjoyment from his social interaction with the therapist whom he evidently revered and admired. In this respect, the patient's use of social humour evidently supported the continuation of the friendly social rapport between himself and the therapist and this would have benefited his therapy goals and his personal social needs. According to the data, the patients in the SCS-001 and SCS-007 case studies may have had similar motives for engaging in social humour and chat with the therapists during the treatment sessions. In the SCS-001 case the patient was observed to chat about people he knew through his therapy and this seemed to be a means to make a social connection with the therapist from which further therapy attention would follow:

Patient to therapist: *"do you know [person's name]?"*
Therapist: *"yeah I know her how is she?"* (SCS-001 Treatment session transcript).

According to the case study summary in chapter 5, the patient was working with an unfamiliar therapist in a one-off session only and this may have prompted him to try to use his social experience in therapy to establish social communication with the therapist. This may have gained the therapist's liking and sympathy and led to what the patient perceived as more effective therapeutic support in the short session. In the SCS-007 case study the patient was more explicit in expressing her desire for social support to the therapist in the treatment session:

Patient to therapist: *"It's quite a friendly atmosphere here because some places you go into are sort of all cold and the people are staid but it's quite relaxed here"*
Therapist: *"The people are friendly. We can't help the environment. Now can I take this* [strapping] *off?"* (SCS-007 Treatment session transcript).

The patient's comment here seemed to confirm that she had the therapist's social attention and understanding in the session. Evidently the patient expected social support from the therapist and other day hospital personnel as part of her treatment regime and she was prepared to speak up to encourage this to happen. However, the excerpt discussed in section 7.4 above suggested that the therapist considered the patient to be too socially dependent on her therapy visits and wished to begin steps to control this at some point in the patient's treatment. These data suggest that social support was important for the patient on a personal level for its own sake rather than simply as a means to gain therapy attention in pursuit of her goals for recovery. The finding that patients may value social interaction during treatment for its personal benefit was further supported by evidence that patients would seek out social support from others in the day hospital setting if this was not forthcoming from therapy staff. In the SCS-006 case study the patient acknowledged that she gained social pleasure and support from her interactions with the other patients in the day hospital community:

Patient: *"we did marbling and ...we play hockey and cricket it's so funny it really is...we all sat opposite each other and it got really vicious...that part I do enjoy it really is good and ...you make a lot of friends there because there's different people coming"* (SCS-006 Patient interview).

This excerpt suggests that the patient had a gregarious social nature and needed social interaction for her personal fulfilment. Perhaps this was how the patient in the SCS-002 treatment session felt as she sought to engage the study observer in social conversation because this was not freely forthcoming from the two therapists who seemed to be focused on treatment issues:

Senior therapist 2: *"Right if I walk [my patient] once more...and then I'll just have a...play around with the parallel bars because I've got time"*
Junior therapist 1: *"Yes okay fine...*[study patient name] *I'll catch you after [the senior therapist is] finished"*
Patient: *"they say it does alright"*
Observer: *"you make me tired looking at you"*
Patient: *"(laughs) you wouldn't think you'd be so tired really it's surprising"*
Observer: *"I'm not surprised"* (SCS-002 Treatment session transcript).

The impression gained from these data is that the patient's social interaction with the observer was a spontaneous attempt to relieve the serious prevailing atmosphere in the treatment session. In this respect, the patient seemed to have felt the need to seek a friendly social contact in the treatment session beyond the two therapists and may have identified the observer as a likely respondent to her social needs. Evidently, social interaction was an important element for the patient, perhaps for reassurance or just conversation. The patient's contrasting social behaviour with the observer and the two therapists suggests that she was sensitive to the different social conventions that were expected of her in her interactions with the different people in the session. Thus, the two therapist's busy professional interactions may have indicated to the patient that they were not receptive to social overtures whilst the observer who was quiet might have seemed more approachable.

7.6 Patient and spouse's avoidance of social interaction to safeguard control

The findings discussed so far suggest that the patients generally sought to gain the attention, sympathy and help of the therapists and employed a variety of social strategies to invite this support and consideration. However, data from one of the case studies showed that not all of the patients followed this philosophy and it was possible that patients might view social interaction as a less important part of treatment and would strive for a greater degree of privacy from the intrusive scrutiny of health professionals into their lives. This act may have created a greater sense of control for the patient over their social life. This feeling was revealed by the patient and his wife in their interview in the CS-4 case study:

Patient's wife: *"we do talk* [in treatment] *about things like oh we've been to a wedding...or...to a party"*
Patient: *"But...you don't go into great detail about ...your personal lives...you don't divulge too much"*
Wife: *"No"*
Patient: *"I doubt if* [the therapist is] *interested that much"*
Wife: *"It's just a bit of chit chat really"*
Patient: *"Yeah. But it's not important I wouldn't think"* (CS-4 Patient interview).

There is a sense that the patient and his wife chose to rely on each other for their personal social support rather than apply to the therapist for this help although they were obviously on friendly terms with her. In this respect, they seemed to conceptualise the therapist as the means for therapeutic support only and did not think that social interaction was an important or necessary part of their work in the day hospital treatment sessions. This was an unusual finding which was not found in any of the other case studies. It is possible that this view may have been influenced by the fact that the patient's spouse was a constant presence in his day hospital treatment or it may have been related to the fact that the patient and his wife were a young couple (according to the demographics in tables 3 and 4 in chapter 5 the patient was a young man in his 40's). The constant presence of his wife may have lent the patient a strong sense of social solidarity in his treatment against the power of the institution particularly as her goal was to be his advocate in therapy according to the case study summary in chapter 5.

The data discussed in this section suggest that patients are sensitive to the social meanings of the interactions in treatment and can use these meanings to conceptualise the roles and helpfulness of personnel who are involved with them in treatment. This information can then be used by patients to gain the social support and attention of therapists and others depending on their individual needs. Since social strategies involve social interaction skills common in everyday life, it is likely that patients have confidence based upon experience in carrying out these strategies. Indeed, the social interactions of treatment could be described as elements in which patients might be considered skilled actors in their own way. However, the findings also highlight how patients can be socially vulnerable in treatment particularly if they rely on social support to meet their personal needs. In this respect social support was clearly an important resource from which patients drew heavily in the treatment sessions.

The data showed that patients were capable of using their social skills to gain social communication from others they encountered in the treatment setting and this power may have given patients a sense of control in their visits to the day hospital. In the one case study where the patient had his wife as co-attendee in treatment it appeared that they preferred to use each other for social support and did not rely on interaction with the therapists or others in the day hospital as the other patients had. This supports the conclusion that social interaction was an important part of treatment for patients because it was an element of treatment that they understood and could control to achieve their aims.

7.7 Summary

This chapter presented and discussed the combined case study data pertaining to the social interactions theme. The results showed that the informal interactions of the social interactions in the sessions were used by therapists to influence patients in several ways. Through a variety of verbal, behavioural and tactile strategies the therapists induced patients to communicate information to them and to become more socially interactive and participative. These outcomes would have benefited the therapists in their work towards therapeutic treatment goals and institutional time-management goals. The social interactions also enabled therapists to control patient behaviour, particularly humour and social gossip that may have compromised their professional standards and position. The results also showed that patients possessed good social awareness and experienced social skills in the treatment sessions and used this knowledge to gain the therapist's social and therapeutic attention and support.

The findings showed that patients' valued social support for its own sake in treatment and would seek this from other personnel in the treatment setting if necessary. These data suggest that patients gained a sense of personal control over their treatment and day hospital visits in their social interactions because of the pleasure and personal fulfilment that was achieved. As the findings suggested that therapists sought to reduce patients' social dependence on therapy it is possible that there was a lack of shared understanding of the significant part that social interaction played in the lives of patients in treatment. It is speculated that this could have a damaging effect on the role that patients fulfil and wish to take in treatment. These issues will be discussed in more detail in the next chapter which will present a general discussion of the findings presented in the previous three chapters. The general discussion chapter will also present the models of social power and partnership which were developed from these data.

Chapter 8 General discussion

8.1 Introduction

This chapter will discuss the interpretations of the study findings presented in the previous three chapters and will develop these through further discussion and modelling. The chapter will consider the findings in relation to existing models of social power in order to explain the meanings of the goal-directed powers of therapists and patients and how these influence the social roles and obligations of 'the professional' and 'the patient' in the institution. A new explanatory model will be described to show how these power interactions can influence the working relationship between therapists and patients making comparisons with existing theoretical models of partnership working in the literature. Consideration will be given to how this new social power interaction model will contribute to knowledge of the social dynamics of the therapeutic relationship and how this can be used to improve shared communication between therapists and patients in the spirit of negotiated partnership agreements. Critical reflection will also be made of the shortcomings and strengths of the methods used in the study in light of its final outcomes. Suggestions for further research will also be given to enhance the credibility of the work and increase the evidence-base in this important area of study.

8.2 Reminder of established knowledge

This research sought to examine the way that physiotherapists and patients utilised power to achieve their individual aims in stroke physiotherapy treatment interactions and how this strategic activity influenced the development of partnership working in treatment. Involving stroke patients as 'partners' in their rehabilitation treatment as the Department of Health (2001a; 2003) recommended was highlighted as a difficult problem for physiotherapists in the literature. This was because patients had their own agendas in treatment (McGrath & Davis, 1992) and therapists had to adjust their communications to manage this (Wiles et al, 2002). Although several authors theorised that social power factors rooted in the institutional rules of the hospital influenced the understandings and interactions of healthcare professionals and patients in treatment (Foucault, 1973; 1982; Rose & Miller, 1992; Swain, 1997; Williams & Harrison, 1999), little was known of how these processes worked or what their implications were for partnership working in physiotherapy practice as few empirical studies had been performed. Key studies which conducted observations of physiotherapy treatment interactions suggested that therapists and patients 'orientated' their interactions around the powerful authority of the professional (Parry, 2001; 2004; Williams & Harrison,

1999) but only therapists seemed to be aware of the significance of this power as they tried to manage its impact in treatment (Harrison & Williams, 2000).

8.3 Discussion of the study's significant findings

8.3.1 Negotiation of leadership interactions establishing the roles of power

This research showed that many of the physiotherapists and patients engaged in interactions which negotiated the therapist taking the leadership role in the sessions. Leadership was also negotiated between two of the therapists who worked together in one of the treatment sessions. In this case, a senior grade therapist invited to give her expert opinion over a treatment case established her authority over the patient and the patient's therapist who was of a junior grade. Negotiation of leadership interactions were identified in all of the primary case studies and in two of the four secondary cases. The prevalence of this theme across most of the data suggests that it was important to the therapists and patients to identify and acknowledge the locus of authority in treatment.

The study revealed that the therapists were chiefly concerned with controlling the management of treatment and the therapeutic setting and in establishing power over the interactions of patients and colleagues who were involved in treatment. As the therapists exerted their authority in this way the intention seemed to be to mould patients and colleagues into 'good patient' and 'good colleague' roles to ensure compliant and co-operative interaction. The therapists' authority negotiations seemed to be intended to minimise opposition from their fellow participants to ensure that treatment time was used as effectively as possible to meet the therapeutic, professional and institutional goals that had to be met. Palvianen et al's (2003) research showed that nurses had similar institutional pressures as they controlled patients' behaviour and activities in order to meet demands of 'efficiency', 'economy' and 'safety'. In accord with this view, therapists in the present study seemed to perceive leadership authority as a necessary tool to manage treatment sessions and other goals rather than something which was a right of their professional status.

The therapists' leadership negotiations with patients were shown in the study to be influential in shaping the role of the 'good patient' as well as the professional role of authority. However, contrary to Foucault (1973; 1982) and Rose & Miller (1992) these roles did not appear to be created through expression of the unchallenged authority strategies of the therapists. The study showed that the patients participated in the therapists' acquisition of the leadership role by giving their consent with co-operative behaviour. This co-operation had a price however, as the patients wished to gain something from the therapists in return. These strategic negotiations of leadership authority and co-operation suggest that the 'therapist' and 'patient' roles were shared constructs developed in the goal-directed interactions of both parties.

From the patients' perspective, supporting the leadership of the therapists seemed to be understood as a means to gain professional expert attention and help towards achieving recovery. The junior therapist's motives for acquiescing with the senior therapist's authority were the same as she sought the expert's knowledge and experience to advance treatment and progress for her patient. As the focus of the present study was the power interactions between therapists and patients, the junior therapist's interactions with the senior therapist will not be discussed in any more detail in this section. However, this is an important area for future research and this question will be addressed at the end of the chapter. From these data it can be concluded that patients understand that they may have limitations of power to achieve what they want in treatment but that they know that this weakness can be countered with strategic behaviour towards authoritative therapists who are perceived to have that power.

According to Tagliacozzo & Mauksch (1972) and Waterworth & Luker (1990), patients' deference and compliance in treatment is based on beliefs of healthcare professionals' expectations of their behaviour and fears that contrary actions would lead to rejection by staff with consequences for recovery. These conclusions were essentially supported in the present study as patients seemed to choose a subordinate role and to consent to the therapists taking the lead in treatment on the understanding that this would lead to attention and help towards recovery. However, only one of the patients in the present study seemed to comply with the therapist's leadership in a resigned acquiescent manner to avoid conflict as Tagliacozzo & Mauksch and Waterworth & Luker suggested. Most of the other patients who participated in the leadership negotiation interactions seemed to act in a more matter of fact way in their decisions to acquiesce with the therapists because this was what was required of them. Indeed, one of the patients took this further and demonstrated his compliance with a show of initiative to impress the therapist with his willingness to work hard. The variability of patients' strategies in the negotiation of leadership suggests that patients may act with varying degrees of confidence in their interactions with therapists, perhaps on the basis of how secure they feel of the therapist's approval.

The traditional conceptualisation of patients as passive recipients of treatment in the institution may be a misguided interpretation of their behaviour. This study showed that patients have a part in shaping the 'patient' and 'therapist' roles through their participation in strategic negotiations with therapists of the power roles of each in treatment. The dynamic nature of this participation shows that patients are active agents in treatment and that they possess some notion of the social rules of treatment and the institution. It also suggests that patients know their own aims and have an understanding of how these may be achieved with their own concepts of power.

Parry's (2001; 2004) conversation analysis study concluded that therapists' and patients' interactions in managing patients' poor physical function 'orientated' their interactions in a pattern which reinforced the therapists' authority and the patients' worthiness as the recipient of treatment. Parry's orientation interactions appear similar to the negotiation of leadership interactions enacted by the participants in the present study. Although the focus and interpretative approaches of this study and the present work were very different, it is interesting that the two showed some consistency in these results as this supports the credibility of each. Parry's work also agreed with the conclusion that the 'therapist' and 'patient' roles are shared constructs negotiated between therapists and patients in interactions in treatment.

8.3.2 Negotiation of communication and information

Communication in stroke physiotherapy treatment has been highlighted as a problem issue for co-operative working because therapists and patients may possess differing communication capabilities (Coulter et al, 1999; Thomas & Parry, 1996) and may have strategic reasons for not wishing to share key information freely in treatment (Hoffman, 1974; Wiles et al, 2002). The present study showed that physiotherapists and patients both used discussion interaction as a strategy in the treatment sessions. However, therapists and patients had differing goals in the discussion interactions and the way in which these individual plans were implemented seemed to influence the power of control of the different participants and their working relations in treatment. Therapists seemed to have several goals in their use of discussion: to gain information and advice, to maximise patient communication, to encourage patient and spouse's participation in treatment negotiation, to inform, educate and explain about treatment and to avoid discussion about the difficult issue of patient recovery. From the range of these goals it can be seen that the therapists desired to control the communications and co-operation of the patients and their spouses through participation, education and control of information resources.

Patients were found to use discussion interaction for more modest ends: to express their views in treatment, to gain information and to oppose therapist plans. The revelation that patients were able to implement communication strategies in these diverse ways suggests that Thomas & Parry (1996) and Coulter et al (1999) may have been too pessimistic in their assumption that stroke patients with communication difficulties would be limited in their ability to participate in negotiations of information in treatment. In two of the case studies the patients demonstrated degrees of expressive communication deficits, from mild to severe. In both of these cases, the patients used or described communication strategies to express their views and feelings to the therapist. These strategies included facial expressions, pointing, verbal sounds of pain and effort and attention to physical posture as sitting up was considered more conducive to effective communication with the therapist than lying down.

Many of the patients across the case studies used non-verbal communication strategies even though they displayed no obvious expressive communication difficulties. This suggests that patients can be competent communicators in their own way even if they are constrained by the effects of the stroke and can adapt the communication skills they have to convey information they feel is important to the healthcare professional. This may be an important factor in patients' ability to participate in partnership working, particularly negotiation of their own views and plans in opposition of the therapists' plans and negotiation of information.

The findings suggest that non-verbal communication interactions may have an important role to play in the development of shared negotiation and partnership working if patients' diverse abilities in communication could be properly acknowledged and supported in treatment. Indeed, it was shown in one of the case studies that therapists could facilitate patient participation in partnership working by implementing structures to simplify patient treatment choices and support communication of preferences. By negotiating control of the patient's communication as well as his treatment choices, the therapist in this case was able to achieve a pragmatic state of concordance in interaction with the patient that was not evident in any other case study. These findings show that a model of partnership working based on negotiation of joint agreement as speculated by Quill (1983), Law et al (1995) and Charles et al (1999) is possible in stroke physiotherapy treatment interactions. They also echo Robson's (2002) analysis of concordance as a state of agreement over the processes of interaction as well as hoped for outcomes.

The study showed that in addition to exerting control over patients' communication interactions the therapists also collected and controlled information in treatment. Therapists' management of information in this manner suggested that information was an important resource that enabled them to maintain control in treatment in pursuit of their goals. In fact, this strategy is recommended in the physiotherapy professional literature as information about the patient and their stroke is needed to enable treatment to be formulated (CSP, 2000). At times however, it appeared that the therapists' goals were beset by conflict. Thus, as the therapists sought to encourage patients to communicate to provide information essential to the management of treatment, they were also trying to discourage discussion interaction to avoid having to address the difficult issue of recovery with patients. Concerns about therapists guarding or not being able to provide information to patients in stroke rehabilitation were raised by Hoffman as early as 1974 and more recently by Wiles et al (1998; 2002). Wiles et al (1998) discussed the possibility that therapists may have been trying to avoid conflict at the eventual outcome of treatment with patients in their strategy of guarding information about recovery during treatment. It is possible that the therapists felt that their professional integrity was at stake in being asked to speculate on recovery which was uncertain.

The present study revealed more details of why therapists might be reticent about sharing information with patients during treatment. These were: lack of familiarity with the patient, lack of clinical experience and the necessity of meeting the goal of discharging the patient. These findings suggested that therapists were forced into using their power to try to cope with the daily problems and pressures of the job which threatened their institutional and therapeutic control and their professionalism and these necessities unavoidably influenced their interactions with patients. These findings again echo the assertions of Palviainen et al (2003) that healthcare professionals' control strategies are directed by institutional priorities.

The present study was not able to supply a solution to the problem that therapists faced in trying to juggle their strategies as they tried to maintain control of their diverse goals in treatment. However, the study did show that patients were active agents in seeking and using information in support of their own aims and this insight may be useful in providing a clearer understanding of how control of information can be negotiated more effectively in practice.

It was found that patients used various verbal and non-verbal communication interactions in treatment to influence the therapists to give them information and reassurance. Moreover, as the findings showed that the therapists used various discussion strategies to encourage patients to give them information it is possible that patients as well as therapists had strategic power in the possession of information resources. These findings suggest that patients and therapists may be using information as a form of currency in their strategic interactions with each other. However, it is not clear whether patients are fully aware of this power. The negotiation interactions over information show that therapists and patients are already involved in social processes of partnership. In terms of partnership interactions, negotiation of information could be identified as a central feature in the development of co-operative action and communication leading to agreement of joint plans. However, strategies may need to be identified to help therapists and patients to become more aware of the value of negotiation interactions particularly of information in facilitating co-operative working and how this could be better planned in their work together.

8.3.3 Negotiation of social power for persuasion

The therapeutic relationship between therapists and patients in occupational therapy and physiotherapy has been highlighted as a significant factor in the development of effective working relations and outcomes of treatment (Lloyd & Maas, 1991; Barnard, 2003). Barnard in particular highlighted the significance of social interactions on the quality of the therapeutic relationship that developed in treatment. The present study identified that social interaction was used by both therapists and patients as a strategy to influence the attitude and behaviour of the other in treatment. However, the purposes of the therapists and patients in using social strategies were found to be very different. The therapists' purposes were to gain information, to encourage patient social communication and to control features of patient behaviour that threatened their professional control in the session. This broad range of goals suggested that therapists approached the social interactions quite pragmatically as potentially useful opportunities to influence the patient in some way. This may agree in part with Adams (1994) who suggested in her study of physiotherapeutic communication interactions that therapists' social therapeutic activities, including empathy and reassurance were focused entirely on the patient with no personal social meaning. In the present study the therapists' social strategies seemed to be focused upon achievement of goals relating to therapeutic plans, institutional priorities of time-management and maintenance of professional distance from the patient.

The therapists' control of the patients' social interaction was interesting as it seemed to contradict the literature which recommends the fostering of a good working relationship with patients (CSP, 2000; Lloyd & Maas, 1991; Barnard, 2003). The therapists appeared to control the patients' social behaviour because this was considered inappropriate in the therapeutic treatment setting. The data showed that the patients sought friendship support in the social interactions in treatment probably because this was important to their sense of wellbeing in their situation and because the social perspective was what they understood in treatment. The therapists however, would have had an entirely different approach to the treatment session as a job and a professional role. Gallop (1998) in a discussion of the boundaries of nurse-client relationships highlighted that healthcare professionals may be at risk of violating their professional trust with patients if they do not maintain strict control over familiarity and other social interactions in their working relations.

As physiotherapists may work with stroke patients over several weeks or months it is perhaps not surprising that patients come to view their interactions as friendship. These principles may have been the prime concern of some of the therapists in the present study as they tried to control the patients' chattiness, over-dependence and bashful over-familiarity in the sessions. However, the therapists' de-socialising strategies were probably also of chief importance in the control of the limited time of the sessions. Whatever the rationales behind the therapists' control of the patients' social interactions it is possible that it was perceived as a negative feature by patients. This speculation is supported by the finding that some of the patients sought social interaction and support from others in the treatment setting including the research observer and other patients. However, the study showed that the patients used social interaction with the therapists as a means to influence their sympathy to give them their approval, professional attention and help and patients would not be able to get this from their surrogate sources of social contact. The patients seemed to derive a sense of personal control over treatment in their social interactions as well as social pleasure in their meetings with people they considered friends and helpers. It is possible that the conflict created by therapists' need to control social interactions in treatment may hinder patients' ability to communicate their wishes and negotiate their social needs.

The patients' manner of using social interaction to influence the therapists' liking and approval in the hope that this would gain them the therapists' professional attention and support is similar to a form of social persuasion called the 'norm of reciprocity' (Smith & Mackie, 1995). The social psychology literature explains that this strategy is effectively used by charity fundraisers who offer the public a small gift to gain their attention with the expectation that people will respond in kind with a goodwill donation (Smith & Mackie, 1995). The social communication interactions in the treatment sessions were evidently monitored and used quite skilfully by the patients, much as they would have been in everyday life. In this respect, it appeared that patients may have concentrated their attention on the social elements in treatment because of their familiarity and meaningfulness to them. As the patients in the primary and secondary case studies were all mature individuals aged 40 and over, it is evident that they had considerable social life-experience and in using social communication to gain what they wanted in their everyday lives.

The important findings were that patients were proficient social actors and agents in treatment as they were capable of pursuing the social goals that were important to them in the social interactions. However, these actions could be subject to control by therapists if these were considered to have crossed acceptable boundaries of behaviour or if they threatened therapists' institutional goals. It is possible that these conflicts in goals could hinder partnership working if no attempt was made to discuss the needs and priorities of the participants in their interactions.

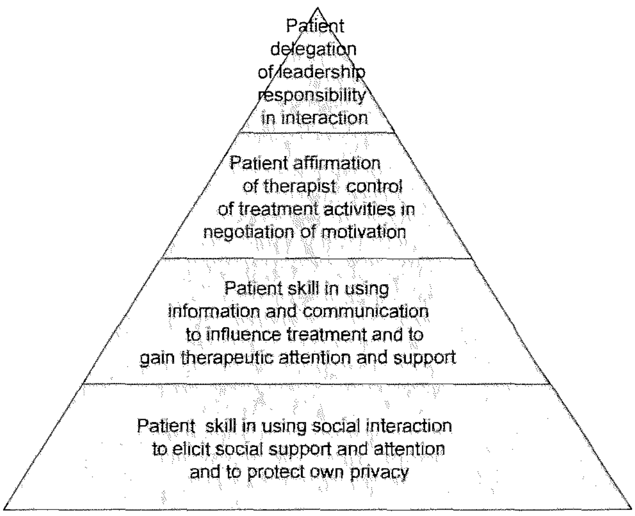
8.4 Reviewing the concept of 'the expert patient'

The Department of Health's Expert Patient initiative (2001a; 2003) asserted that patients should be helped to be active participants in treatment, offering their views and negotiating their preferences with therapists. The present study showed that patients were in many cases already taking on these activities, sometimes with the structured support of therapists. However, does this mean that patients are now eligible to be called 'expert patients'? Whilst the study has shown that patients are capable of taking part in communication and social negotiations with therapists and can use information resources as agents in pursuit of their own goals, it is unlikely that patients want to be considered 'experts'. Indeed, the general view of the study patients seemed to be that they expected therapists to be the experts. This sentiment was confirmed in the patients' strategic activity in the sessions as they tried to persuade therapists to provide them with expert attention and support by demonstrating 'good patient' behaviours in the leadership negotiations, communication interactions and social interactions. The patients also showed little interest in challenging the therapists' control of the treatment activities and again demonstrated 'good patient' behaviour in negotiating their motivation to work hard in treatment. Prior (2003) seemed to bear out this view in his comment that patients did not possess the knowledge or skill to manage treatment or to interact with therapists as 'expert colleagues'.

The present study has shown that the 'expertise' of patients (or their skill) is in their social knowledge and experience and their ability to use these resources in social communication and negotiation with therapists to exert influence to gain what they want. Lukes (2002) described the ability to use influence in pursuit of one's goals as a form of social power. He also described the ability to 'assign responsibility' as a strategy of power and this suggests that the patients' support of the therapists' leadership with acquiescence was a delegation of social power also.

Figure 2 presents a model of the patients' 'expert' power and how this interacts with the therapists' expertise in the patients' goal-directed plans:

Figure 2. Model of patients' social influence skills in interaction with therapists



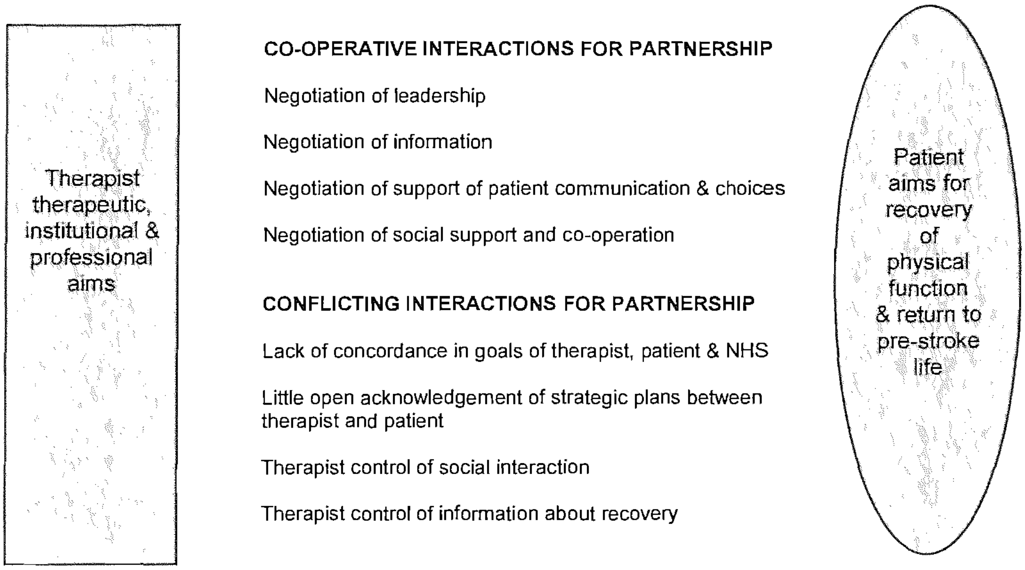
From the above model it can be seen that social and communication interactions are fundamental building blocks of patients' power in treatment interactions as they offer patients the greatest opportunities for negotiation and influence with therapists in pursuit of aims. The model also illustrates how patients use their social influence skills in interaction with therapists to gain the therapists' expertise. In essence the model shows how the powers of patients and therapists interact from the perspective of the patients' strategic plans. The conclusion gained from these findings is that patients are by no means the passive recipients of treatment, hindered from negotiating their own plans with therapists because of age or stroke-related disabilities or social inferiority in the institution as the early literature suggested (Foucault, 1973; 1982; Ley, 1988; Coulter, 1997; Hildick-Smith, 2000). Patients' social powers of influence enable them to participate in treatment in a 'patient' role that they feel is necessary to achieve their goals and not one which is dictated by the institution or society as a social virtue (Rose & Miller, 1992). However, does this new definition of 'patient power' constitute a partnership role or should the concept of the patient partnership be redefined also?

8.5 Implications for partnership working

Despite the evidence that patients have the ability to act and to exert some control over their own social agendas in treatment, it is not clear that this agrees with the Department of Health's (2001a; 2003) concept of the patient as an 'expert partner' in treatment and in the long-term management of stroke. The patients' goals in the study were identified as receiving as much therapy as possible and achieving complete recovery. These seem to be quite stable goals of stroke patients as they correspond closely to those identified by Pound et al in their work (1994a). The patients' strategic actions in pursuit of these goals in the study were generally intended to culture the therapists' expertise and support. This suggested that patients desired to delegate control and responsibility to the professional rather than to take on this responsibility themselves which is what the Department of Health proposed in the 'expert patient' initiative (2001a; 2003). These conclusions suggest that the problems preventing patients from engaging as 'expert partners' with physiotherapists in treatment may relate to the fundamental differences in the goals of patients, healthcare professionals and the government who all seem to desire co-operative working practices in treatment for different reasons.

Partnership was defined in the literature as a process of negotiation where participants agreed upon goals and the roles and responsibilities of each in practice of these plans (Quill, 1983; Law et al, 1995; Charles et al, 1999). This was further qualified as concordance where participants negotiated agreement of co-operative working for the mutual benefit and goal-achievement of both parties (Robson, 2002). The study findings revealed that therapists and patients interacted with remarkable co-operation in many respects, particularly in the allocation of leadership and the negotiation of communication and social support and information. However, the study also revealed that there was often little open acknowledgement of strategic activities and some interactions involved the use of power in a manner which seemed to conflict with the principles of co-operative partnership or collaborative concordance. The model in Figure 3 (overleaf) presents these points:

Figure 3.Interaction influences on partnership working



The model in Figure 3 illustrates how the interactions between therapists and patients in treatment are capable of supporting elements of partnership working although with little open acknowledgement of these agreement negotiations. Coulter (1997) discounted the ideal of partnership working in theory because as she explained, there was precious little evidence of these activities taking place in practice. Whilst the present study showed that therapists and patients could work in co-operation, negotiating certain interactions for their individual and occasionally mutual benefit, it is clear from Figure 3 that much still needs to be done to support better co-ordination of goals of therapists, patients and the institution and to help patients and therapists to communicate about their strategic activities more clearly. It is doubtful if these ideals are achievable in the present treatment context. The present study findings suggested that the institutional demands of time on therapists are extremely powerful and this may mean that they will be difficult to control and alter. Moreover, the patients in the study seemed content with their existing power relations with the therapists and seemed happy to continue in their chosen role as 'the good patient' and this understanding may be difficult to change.

Greenwell (1996) asserted that patients were consumers and not 'partners' in healthcare and as such did not need to aspire to any degree of 'expertise' to achieve what they wanted. In this model, patients could simply use what bargaining power they had to negotiate for the services they felt they needed from proficient healthcare providers and this would suffice for their purposes as the consumer-patient. This study has shown that patients do possess bargaining power in the form of information, compliance or 'good patient-hood' and social interaction. However, patients may not be fully aware of the strategic significance of this power without this being discussed openly with therapists in treatment. Perhaps government initiatives should focus on developing strategies to improve patient awareness of the strategic significance of their social skills and in encouraging shared communication of these activities in practice. Consideration might also be given to supporting healthcare professionals in managing the demands of limited time resources in the institution to minimise the impact this issue has on therapist-patient social interaction and communication.

8.6 Summary of conclusions and contributions to knowledge

This research has made a contribution towards understanding the dynamics of the social power interactions between therapists and patients in stroke physiotherapy treatment and in explaining how the negotiation of these strategic relations influences the development of the working relationship and the roles of 'the professional' and 'the patient' in the institution. Through its examination of the strategic interactions of therapists and patients and the aims which each strove to achieve in treatment, the study has developed a model which explains more clearly the social meaning of patient 'expertise' and how this is created in interaction with the power strategies of the patient and the professional. The model showed that patients possessed power in the negotiation of social interactions and information and these offered opportunities for influence with therapists and could promote patients' aims. It also showed that patients' choose an acquiescent role in treatment in upholding the leadership of the therapist.

This behaviour in addition to their strategic social and communication interactions indicated that patients were not passively accepting of the ministrations of therapists but were active agents influencing the roles of power and the course of treatment. This is a significant advance in understanding the nature of the patient role and the degree of participation that patients are capable of in physiotherapy treatment interactions. The identification of the patient as a consumer with considerable social bargaining power and the ability to use this in treatment shows that the Department of Health's focus on increasing patient participation may be misguided. However, there appeared to be little open acknowledgement between the therapists and patients of their strategic activities and perhaps because of this patients and therapists did not seem able to achieve concordance in their goals and strategic interactions. This is a new problem that should be addressed in further research or in government initiatives for support.

8.7 Critical appraisal of research methods

It is felt that the qualitative case study methods used in this research were appropriate for the sociological inquiry into the strategic power interactions of therapists and patients in stroke physiotherapy treatment. These methods, comprising exploratory focus group discussions with therapists and qualitative case studies of the stroke physiotherapy treatment interaction in situ, facilitated the development of a detailed theoretical insight of how symbolic social power interactions influenced the emergence of the 'therapist' and 'patient' roles and the negotiation of treatment. Moreover, the triangulated approach that was achieved by collating the different interpreted realities of the therapists, the patients and the researcher enabled a comprehensive understanding of the phenomenon and increased the credibility of the results in accordance with good research practice (Mays & Pope, 1995).

However, the methods used were not without their problems. In particular, the process of audio-taping the treatment sessions proved to be less practical in practice than in principle. This was because the physiotherapy treatment sessions were very active and noisy, involving as they did a great deal of movement of the participants around a wide area of the gymnasium and on and off pieces of equipment. To compound the problem, the treatment gymnasiums were sometimes populated by other therapy dyads not involved in the study. Whilst the verbal communications of these pairs were generally not recorded with clarity alongside the study sessions, they contributed a form of audio interference on the tapes which made the study session recordings more difficult to transcribe.

Such difficulties in obtaining consistently good recordings of the verbal interactions between the study participants during the treatment sessions may be considered difficult to avoid in research in busy public healthcare institutions. Alternatives to the use of audio-taping in the treatment sessions may have been video recording or taking written notes of the interactions. Video recordings of the treatment interactions would have provided an additional degree of visual detail in the data. However, use of this tool was dismissed as such an intense level of detail was not considered necessary for the study's social level of analysis. Moreover, it was speculated that the intrusive effects of the camera equipment could have caused additional discomfort to the participants. The other alternative of taking written field notes of the interaction events in the treatment sessions was used to a limited degree in the study. Using the prepared observation schedule, brief notes on events, activities and interactions were taken to annotate the audio recording with a basic structure of aide memoirs. This provided useful references which were written up in conjunction with the audio-recording shortly after the treatment session was completed and this produced detailed field notes which helped in the interpretation of the data.

8.8 Critical appraisal of the secondary analysis process

The secondary analysis process presented different challenges for the researcher compared with the analysis of the main case study data. These problems chiefly related to difficulties in achieving a consistent degree of depth in the analysis of the secondary data. Whilst it was speculated that this may inevitably be a consequence of trying to impose a fresh analytical framework on data which had been collected using a different research focus, it is useful to consider the impact of the secondary analysis process more closely. This may provide a clearer insight into the different challenges that were presented by the secondary analysis process and the implications the use of this method had upon the study and its outcomes.

The use of the 'cases' from the secondary study was justified in chapter 3 of the thesis on the basis of these being a necessary adjunctive source of related qualitative data which could contribute to the explanatory power of the present study. As the original case studies conducted in the present study were comparatively few, despite the depth of observation they achieved, it was necessary to supplement these with additional reliable sets of data which had been collected with similar methods in similar clinical contexts. On this basis, the secondary data proved to be invaluable additions to the study as they furthered the explanatory power of the thesis across a greater number of cases. This rationale is supported by Kelder (2005) who used secondary data analysis as a valid method of substantiating primary observational research in the field.

Only four of the eleven 'data-sets' from the secondary study were able to be used for the secondary analysis process. This was due to the limited time resources and also the fact that the secondary data-archive that was accessed for the present study's purposes comprised incomplete transcripts of some of the observation and field notes data. As these sections of the data-sets were to be the most pertinent sources from which the strategic power interactions of the therapists and patients could be interpreted, it was important that they be as complete as possible. It was impossible to remove the constraint of the researcher's lesser involvement in the secondary data, particularly the observational data. Whilst the secondary data interpretations were discussed at length with two of the researchers from the secondary study, the experience of taking part in the treatment sessions of the primary case studies enabled a deeper level of understanding to be developed about the data. In discussing this problem, van den Berg (2005) suggests that the root of the difficulty is the secondary analysts' lack of 'contextual detail' from the original research setting. The significant element of detail that secondary analysts lack is the social interaction between researcher and participant and this can constrain in-depth interpretative analysis of the data (van den Berg, 2005).

In the present research context, this problem was experienced to some extent in working with the interview data, which seemed to lack definition compared to the primary data which I collected myself. This issue highlights the social constructionist underpinnings of the present research's data collection and analysis methods and suggests that the meanings of the data may be less intense in instances where secondary data are used (Bryman, 2001). However, this was felt to be less of a problem with the treatment session data which had more contextual information available in the form of field notes and background demographic details in the Personal Profile data. As van den Berg (2005) advises, the use of secondary analysis has to be supported by supplementary information relating to context and background to enable the latest interpreter to understand the messages in the data.

Whilst the study encountered some difficulties using the secondary data analysis process, this was nonetheless a useful part of the PhD which had several positive outcomes. Firstly, the secondary data analyses developed the analytic power of the study's interpretative framework to a useful degree. Secondly, the process allowed the conclusions of the primary research from which the secondary data were sourced to be developed further thus strengthening the link between the present study and its parent work. Lastly, the secondary analysis process enabled development of the research skills of the student researcher in an interesting way.

8.9 Extraneous influences upon the study

Considerable difficulties were experienced in effecting the research plans at times. This was due to several factors extraneous to the study which proved to be difficult to control. Amongst these problems were delays in achieving timely completion of the ethics and NHS approvals of the studies. It is noted that these necessary official ratification processes have become increasingly more complex in recent times due to changes in the legislation of research governance. In view of these difficulties it may be prudent to consider the increased length of time it may take to plan and establish a research project and to budget resources of time and funding for this accordingly.

Another factor which influenced the progress of the project was the major structural development of the stroke services in the hospital Trust during the course of the study. Amongst other problems, these developments affected frequent changes in the working environments of the day hospital physiotherapists and this undoubtedly influenced the degree to which they were able to participate in recruitment of patients and data collection in the case studies. The study was eventually able to successfully complete four case studies in this Trust and this was due in no small part to the dedicated co-operation of the day hospital physiotherapists. The addition of another research site following further ethical approval enabled completion of two more primary case studies.

8.10 Further research recommendations

The study highlights some key areas for further research development to achieve greater understanding of the issues of strategic power and its effect upon partnership relations. Whilst the present study was able to achieve an explanation about the dynamic power relations in stroke physiotherapy it is acknowledged that further research could usefully develop this further to achieve a more comprehensive theoretical model. In this respect, it is felt that a larger study with greater resources may be able to build upon the existing framework developed in the present study to achieve a more comprehensive theoretical model. This might be of particular importance to fully explain how therapists can overcome the difficulties of trying to achieve their therapeutic and professional goals in accordance with the priorities of the NHS. This might also help to discover how the negotiation of expectations of recovery between therapists and patients could be more effectively reached in practice.

Another area which might benefit from further development is the significance of the inter-therapist power relations in treatment upon the patient's perception of their role and their participation. The present study's findings suggested that the way that junior therapists interact with their therapy assistants and more senior colleagues during the course of patient treatment is complex in its negotiation of leadership, expertise and social interaction. As therapists' achievement of their professional goals is evidently an important part of the maintenance of their identity in the institution, it seems likely that their hierarchical interactions with their colleagues helped create this. In multiple interactions between therapist groups and patients in treatment, it is possible that the patient's social identity and powers might be suppressed further to the detriment of their working relations and shared participation with the individual therapists and the professional group as a whole.

APPENDIX A

Ethics approval letter for stage two study

Isle of Wight, Portsmouth & SE Hants
Local Research Ethics Committee

Finchdean House
Milton Road
Portsmouth
PO3 6DP

Direct Line: 023 9283 5139
Fax: 023 9285 5312

13 October 2003

Ms F Knapp
Postgraduate Research Student
HRRU School of Health Professions &
Rehab
Southampton University
HighField
Southampton
SO17 1BJ

Dear Ms Knapp

LREC Prop: 09/03/1569
Partnership and Power in stoke physiotherapy

This is to inform you that the Local Research Ethics Committee has approved the above study at its meeting on 10 October 2003. Approval for the study is only granted until the end of October 2004. If your study continues after this date further Ethics Committee approval will be required.

The following documents were reviewed:

Protocol	Dated 17/9/2003
Patient consent form	Version 1 dated 19/82003
Patient preference about information form	Version 1 dated 17/9/2003
Patient information sheet	Version 1 dated 29/8/2003
Consultant information sheet	Version 1 dated 17/9/2003
Consultant consent form	Version 1 dated 17/9/2003
Letter to GP	Version 3 dated 19/8/2003
Information Sheet for physiotherapists	Version 1 dated 29/8/2003
Physiotherapists Consent form	Version 1 dated 19/8/2003
Observation field notes schedule	Version 1 dated 25/8/2003
Semi-structured Interview guide	Version 1 dated 7/9/2003
CV	For Ms F Knapp

- The Ethics Committee will require a copy of the completed study for its records. You are therefore requested to submit a copy of the completed study to the address above.
- The Committee must be informed of any untoward or adverse events, which occur during the course of the study.
- Please inform the Committee promptly if the study is withdrawn, or does not take place.

- The Ethics Committee must also be informed of, and approve, any proposed amendments to your initial application.

- Please note it is the policy of the Committee NOT to deal direct with sponsoring companies. All correspondence (including telephone enquiries) MUST be from the first named researcher. Enquiries from other sources will be refused.

- Ethics Committee approval means that the proposal is ethically sound. It does not mean approval of resources, access to data or any other requirement relating to the project. These must be agreed with the organisation where the research / project is to take place.

The committee thanks you for attending the meeting, which the committee found very useful.

If you have any further questions please do not hesitate to contact me quoting the Research Ethics Committee Proposal Number given above.

Yours sincerely

Claire Fleming
Administrator to the Research Ethics Committee

E-mail: Claire.Fleming@ports.nhs.uk

NB: The Committee endorses the Royal College of Physicians Report on 'Fraud & Misconduct in Medical Research Practice 1991'. This states that all original data (eg questionnaires, lab books, hard copies of any computer data) are kept for a minimum of ten years in a retrievable form. If storage is to be outside either Portsmouth Hospitals or Portsmouth HealthCare NHS Trusts' premises, the Committee must be informed of the site of storage. It is a condition of any approval that such storage occurs.

APPENDIX B

Stage one study participants' documents:
Physiotherapy superintendent introductory letter
Physiotherapist information sheet
Physiotherapist consent form

Health and
Rehabilitation
Research Unit

Professor Ann Ashburn
PhD MPhil MCSP
Head of Unit

School of Health
Professions and
Rehabilitation Sciences

Professor R E Barnitt
PhD MSc FCOT
Head of School

University of Southampton
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WWW http://www.sohp.soton.ac.uk/sohp/

(physiotherapy superintendent introductory letter)

Name
Address

Date

Dear

My name is Fran Knapp, I am a research student at Southampton University and I would like to introduce you to a study that I am conducting. It is funded by the Stroke Association and aims to explore how patients and physiotherapists communicate as they work through the aims and plans of physiotherapy treatment. Previous research suggests that this may be a difficult process and the present study aims to find ways to improve it. It is hoped that such improvements will encourage and support patients' involvement in the plans of stroke physiotherapy, which in turn may increase both patient and carers' understanding and satisfaction at outcome.

The study intends to invite Senior II and Senior I grade physiotherapists with experience in stroke rehabilitation who are currently practising in neurology in-patient and out-patient departments, to take part in focus group discussions. We will be conducting separate discussion groups with individuals who have had physiotherapy for stroke in the past and their carers, but the groups will not share information.

I have identified your department through discussion with senior research staff at Southampton University and I wonder if your staff would be interested in taking part in one of the physiotherapist focus groups? The groups could be held at a convenient place and time and would last about one hour. Refreshments will be provided.

I would be happy to visit the department to discuss the study and to answer any questions that the physiotherapists may have about taking part. I will provide information sheets and consent forms which interested staff can be given to read and consider in their own time. When the study is completed, I would be happy to return to speak to you and your staff on the conclusions drawn from the results of the study.

I will telephone you within the next week to discuss the study. In the meantime, please do not hesitate to contact me if you have any questions. Telephone: 023 80595906 (answer-machine after 5.30pm). Thank you for your attention.

Yours sincerely,

Fran Knapp

Health Research
Podiatry
Occupational Therapy
Rehabilitation Research
Physiotherapy
Rehabilitation Medicine
University
of Southampton

Health and
Rehabilitation
Research Unit

Professor Ann Ashburn
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Head of Unit

School of Health
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Information Sheet for Physiotherapists

Communication problems preventing stroke patients participating in physiotherapy treatment plans

What the study is about and its aims

This research project focuses on the process of communication between patients and physiotherapists in stroke rehabilitation. Previous research suggests that this may be a difficult process and the present study will use focus groups to find out about the problems that hinder the negotiation of treatment aims and plans during the course of physiotherapy. The study aims to identify ways to improve the communication between physiotherapists and patients as they work through the aims and plans of physiotherapy treatment and to develop these measures for use in clinical practice. The study will comprise six audio-taped focus groups with physiotherapists and six with individuals who have completed physiotherapy after stroke and their main carers. The groups will not share information. The focus groups will be held in sites across Southampton, Portsmouth and Bournemouth.

Why you have been asked to take part

You have been invited to take part in this study because you are a Senior II or Senior I grade physiotherapist, with experience of stroke rehabilitation, currently practising in neurology in-patient or out-patient departments. It is envisaged that with your experience, you will have views and ideas which can contribute to understanding the problems in communicating with patients about treatment aims and plans in stroke physiotherapy. Your superintendent will have given you this information sheet describing the study and what will be expected of you if you decide to take part. Two consent form copies are also enclosed. Please take them away and read them carefully in your own time. The study co-ordinator is available via telephone to answer any queries you may have and will be visiting your department within 1 week to give further information if required and to obtain signed consent from those willing to take part. You will keep one copy of the signed consent form and the information sheet. You are under no obligation to take part in this study and can withdraw at any time without giving a reason.

What will happen to me if I take part?

You will be invited to take part in one focus group lasting about one hour at a location and time convenient to you. The study co-ordinator will contact you by telephone to arrange this. The group will comprise physiotherapists with experience of working in stroke rehabilitation. The group members will be asked to discuss their views on topics relating to communication between patients and physiotherapists in stroke rehabilitation. The topics covered will be: current communication practice as patients and physiotherapists work through the aims and plans of treatment; physiotherapists' views on patients' understanding, interest and involvement in the treatment plan; identification of specific factors preventing patient participation; suggestions of ways and means to support shared participation in treatment plans, to increase patient and carer understanding and satisfaction at outcome. There will be two study personnel present in the focus group – one moderator and one observer. The moderator will chair the group and introduce the topics, asking the group to give its views or to clarify details. The observer will make notes on the group discussion. Refreshments will be provided.

Will my taking part be anonymous and confidential?

The focus groups will be audio-taped. Although you will be asked to give your first name to the group, this will not be used to identify any information you contribute to the study. All information taken from the audio-tapes will be made anonymous. All tapes and information collected and processed will be stored in a secure locked cabinet and will be kept strictly confidential by the study team.

How will the focus group information be used?

The discussion information from the focus group audio-tapes will be written out and analysed to develop a theory of communication problems in the treatment plans of stroke physiotherapy.

Who is organising and funding the study?

The research team consists of Fran Knapp who is a social science research student and Dr Rose Wiles and Professor Ann Ashburn who are supervising the project. All are based at the Health and Rehabilitation Research Unit at the University of Southampton. The study is being funded by the Stroke Association.

Who to contact for more information

Please do not hesitate to contact Fran Knapp who is co-ordinating the study on 023 80595906 (answer-machine after 5.30pm), if you require further information or have any questions about the study. The study team would like to thank you for your interest.

Version 4. 29/04/02

Health and
Rehabilitation
Research Unit

Professor Ann Ashburn
PhD MPhil MCSP
Head of Unit

School of Health
Professions and
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Professor R E Barnitt
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Physiotherapist Consent Form

Communication problems preventing stroke patients participating in physiotherapy treatment plans

Please initial box

1. I confirm that I have read and understand the information sheet given to me for the above study and have had the opportunity to ask questions. ☐
2. I am happy to participate in a focus group discussion with other physiotherapists which will be audio-taped. ☐
3. I understand that all tapes and information collected and processed will be stored in a secure locked cabinet and will be kept strictly confidential by the study team. ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

I agree to take part in this study

Name..

Work Address ....

....

Work Telephone Number ....

Signature.. Date...............

Version 3. 29/04/02

APPENDIX C

Focus group topic guide

Focus group topic guide development outline

Focus Group Topic Guides

Communication Problems Preventing Stroke Patients' Participating in Physiotherapy Treatment Plans

Physiotherapist groups

* current practice in the communication of aims and plans during stroke physiotherapy treatment;

* physiotherapists' views on patients' understanding, interest and involvement in the treatment plan;

* identification of specific factors preventing patient participation;

* suggestions of ways and means to improve communication of the treatment plan during the course of physiotherapy treatment and suggestion of how to encourage and support patient involvement.

* physiotherapists' views on how to adapt such recommendations for practical use in clinical practice.

Topic guide development over first phase focus groups

The initial topic guides were developed on the basis of the literature evidence but subsequent guides were constructed on the basis of the emerging theory. This summary illustrates the development of the topic guide as a theoretical sampling tool.

Focus groups 1 and 2

* Aims of stroke physiotherapy from physiotherapist perspective.
* The nature and use of treatment plans in stroke physiotherapy.
* Physiotherapists' perceptions of patient's understanding and expectations in stroke rehabilitation.
* How treatment plans, recovery and patient's expectations are discussed during treatment.
* Physiotherapists' perceptions of patient's preferences for involvement in treatment and its plans and the role of carers during treatment.
* Consideration of ways to support greater patient and carer involvement in treatment.

Focus group 3

* Exploration of the difficulties that therapists experience in helping patients to understand what is happening in treatment, recovery and long-term plans and exploration of ways to support shared understanding and communication.
* Discussion of therapists' perceptions of patient engagement with treatment as rehabilitation progresses and exploration of what might help patients to own the plans of their rehabilitation.
* Discussion of the reality of 'partnerships' that therapists experience in working with stroke patients in clinical practise.
* Discussion of the social and emotional barriers to involvement and partnerships.
* Exploration of what might support the building of effective partnerships in therapy and the rationale for partnerships in stroke physiotherapy from physio perspective.
* Influence of time and wider rehabilitation team on patient/therapist interaction and patient expectations.
* Discussion of various involvement interventions suggested in previous groups such as patient-held diaries, video and contracts and how these may influence the emergence of partnership relationship.

Focus group 4

* Discussion of influence and significance of treatment stage on patient understanding and involvement.
* Discussion of concept of empowerment in treatment and what might hinder this.
* Discussion of problems of patient understanding of goal-setting process highlighted in previous group.
* Discussion of principles of partnerships with patients and the realities and problems in shared understanding, communication and documentation of treatment plans and progress.
* Discussion of known and new support strategies and interventions.

Focus group 5

* Discussion of development of patient insight into stroke event.
* The problems of information provision during therapy and the significance of the timing of treatment and support interventions in accord with patient's comprehension and preference.
* Discussion of patient readiness or reticence to participate in therapy and its plans and how therapists deal with patients who choose not to take part and the implications this may have for partnership development.

Focus group 6

* Discussion of patient reluctance to take part in therapy and the possible reasons for this.
* Discussion of patient's emotional and motivational development during treatment and how therapists assess this and how they intervene.
* Exploration of concept of patient choice and how physiotherapists view this and incorporate this into rehabilitation and its implications for empowerment and partnership strategies that might be considered.

Focus group 7

* Discussion of theoretical and interpretative development of results and conclusions with physiotherapists.

APPENDIX D

Stage two study observation field notes schedule

Observation Field Notes Schedule (Version 1. 25/08/03)

Date of observation: **Time:**
Location code: **Treatment session number:**
Participant identity codes: Patient - **Therapist -**

Observation focus	**Observation data and notes**
Environment	
Sketch of setting layout: Identify participants by code labels:	
Participants	
Characteristics of patient: Characteristics of physiotherapist	
Orientation of power in interaction	***Patient*** ***Physiotherapist***
Unilateral / Competitive orientation: Bilateral / Co-operative orientation:	

Power in use of space	***Patient*** ***Physiotherapist***
Social space: Interpersonal space:	
Power in use of body movement	***Patient*** ***Physiotherapist***
Power in use of physical touch	***Patient*** ***Physiotherapist***
Power in use of voice (non-speech)	***Patient*** ***Physiotherapist***
Details of any tools/interventions used	***Patient*** ***Physiotherapist***

Adapted from Hargie & Dickson (2004), Deutsch (2000) and Coleman (2000)

APPENDIX E

Stage two study Consultants introductory letter
Consultants approval form

University of Southampton

School of Health Professions and Rehabilitation Sciences

Professor Maureen J Simmonds, Head of School

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United Kingdom

Tel +44 (0)23 8059 2142
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Web www.sohp.soton.ac.uk/sohp/

Dear Dr

Re: Research study 'Individual strategies in stroke physiotherapy treatment plans and their influence on partnership'
Ethics approval number:

My name is Fran Knapp and I am a postgraduate research student at the School of Health Professions & Rehabilitation Sciences at Southampton University. I am conducting a research study examining the strategies used by patients and physiotherapists in out-patient stroke physiotherapy treatment sessions as they each try to achieve their own plans and examining how this influences the development of partnership working.

I plan to conduct 15 case studies each comprising observation and audio-taping of one out-patient stroke physiotherapy treatment session and one follow-up interview each with the patient and the physiotherapist which will also be audio-taped. As per the amended protocol (dated 23/02/04) approved by the Portsmouth Local Research Ethics Committee on 08/03/04, the sample of 15 patients would be recruited from the over-65 out-patient (day hospital) services in Primary Care Trusts (PCT's) and identified by the out-patient (day hospital) physiotherapists working in these services. The out-patient (day hospital) physiotherapists would be recruited from the same services as per the original protocol (dated 17/09/03). The observations and interviews would be carried out by me. The observed out-patient treatment sessions would take place in the day hospitals of the PCT's. The patient interviews would be conducted in the patient's own home and the physiotherapist interviews at a time and place convenient to them that did not impinge on working time.

A more detailed summary of the amended protocol (dated 23/02/04) is enclosed for your information. I would be happy to discuss the study with you. My contact number is: 023 80595906 (answer-machine). If you are happy to do so I would be very grateful if you would give your permission for your patients to be considered for this study by completing and signing the enclosed consent form and returning it in the pre-paid envelope provided.

Thank you for your help.

Yours sincerely,

Fran Knapp

University
of Southampton

School of Health Professions and Rehabilitation Sciences

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Consultants' consent form

Re: 'Individual strategies in stroke physiotherapy treatment plans and their influence on partnership'

I am happy for my patients to be approached about taking part in the above study ☐

I do not wish my patients to be approached about taking part in the above study ☐

Name: ....

Signature: .... Date: ....

Version 1. 17/09/03

Please return to:

Fran Knapp
Postgraduate Research Student
Room 0010
School of Health Profession & Rehabilitation Sciences
Southampton University
Highfield Southampton SO17 1BJ

APPENDIX F

Stage two study participants' documents

Out-patients' physiotherapists' introductory letter

Physiotherapist information sheet

Physiotherapist consent form

Patient information sheet

Patient 'preference for information' form

Patient consent form

Letter to General Practitioners

University of Southampton

School of Health Professions and Rehabilitation Sciences

Professor Maureen J Simmonds, Head of School

University of Southampton, Highfield, Southampton
SO17 1BJ United Kingdom
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Web www.sohp.soton.ac.uk/sohp/

The Physiotherapists
Over-65 Out-patient (Day Hospital) Stroke Physiotherapy Services

Date

Dear

Re: Research study: 'Individual strategies in stroke physiotherapy treatment plans and their influence on partnership'
Ethics Approval No.: 09/03/1569

You will have been introduced to the above study already by the specialist stroke superintendent physiotherapist when you were approached about being a participant. I am writing to you now to ask if you would be willing to assist me, Fran Knapp, in the recruitment of patients from the over-65 out-patient (Day Hospital) stroke physiotherapy treatment lists to take part in the study. Your involvement in the patient recruitment process will be entirely voluntary.

The study plans to recruit 15 stroke patients to take part in case studies of their out-patient physiotherapy treatment interactions with their out-patient physiotherapists. Patients are being recruited to take part in the study from the over-65 out-patient (Day Hospital) stroke physiotherapy treatment services in
PCT's from the Day Hospitals. If you are happy to assist in recruiting patients, I would like you to give an information pack about the study to all patients who meet the following criteria:

* Currently receiving out-patient (Day Hospital) physiotherapy treatment following first stroke.
* Received a period of in-patient physiotherapy treatment following first stroke event.
* Aged 65 years and over.

You will be able to discuss any queries about the inclusion criteria with me providing the patient's identity is not discussed in keeping with Data Protection guidelines. I would like you to approach eligible patients at the end of one of the treatment sessions to introduce the study and to give out information packs for patients to take home to read and consider in their own time. This would complete the out-patient physiotherapist involvement in the patient recruitment process.

The information packs given to patients will contain an information sheet with my name and contact number clearly documented and a 'preference about information' form with an attached pre-paid return envelope. The information sheet will ask patients to complete this 'preference' form to indicate whether they were interested in knowing more about the study and in meeting me in their homes to discuss the study. Patients can then return the form by post to me in the post-paid envelope provided. I will then liaise with patients directly by phone to arrange a visit to talk about the study and will obtain consent from those who were happy to take part in the case studies.

I would be happy to speak to you if you have any questions about being involved in the patient recruitment process. Please contact me on telephone 023 80595906 (answer-machine). Thank you for your time.

Yours sincerely,

Fran Knapp

Postgraduate Research Student

Version 1. 23 02 04

University
of Southampton

School of Health Professions and Rehabilitation Sciences
Professor Maureen J Simmonds, Head of School

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Information Sheet for Physiotherapists

Individual strategies in stroke physiotherapy treatment plans and their influence on partnership

What the study is about

This research study examines the strategies that patients and physiotherapists use in the out-patient stroke physiotherapy interaction as they each strive to achieve what they want from treatment. The study aims to identify how such strategies are employed, understood and communicated between therapists and patients during treatment and to find out how this affects the way that patients and therapists work together as partners in treatment. It is hoped that this may lead to a better understanding of how patients and therapists interact during treatment as they try to achieve their own plans. It is also hoped that it may highlight ways to improve the way that patients and therapists communicate about their own plans in treatment and how they may be supported in establishing partnership working which may improve shared understanding and mutual satisfaction at the end of treatment.

What will happen to me if I take part?

The study will involve the researcher observing and audio-taping one or more of your out-patient treatment sessions. You will also be invited to take part in a follow-up interview after each observed treatment session. This will last about 30 minutes, will be audio-taped and will be held at a time and place convenient to you. The researcher will contact you by telephone to arrange this. Patients will take part in a separate interview at home. The interview will involve discussion of what you felt you wanted to achieve in the treatment session; what power you felt you had to achieve what you wanted and how ready you felt about using it; what strategies you used to try to achieve what you wanted and how easy you found it to share these plans and strategies with the patient during the session; now involved you felt the patient was in treatment.

Will my taking part be anonymous and confidential?

The observed treatment sessions and interviews will be audio-taped. Although your name may be used during the treatment session and you will be asked to give your first name at the start of the interview, this will not be used to identify any information you contribute to the study. All information from the audio-tapes and observations will be made anonymous and identified by a unique code number only. All tapes and information collected and processed will be held in a secure locked cabinet and will be kept confidential by the study team.

What should I do now?

You will have been given this information sheet by the superintendent physiotherapist which explains about the study and what taking part would involve. Two consent forms are enclosed. Please take these documents away and read them carefully in your own time. The researcher is available by telephone to answer any questions you may have. Contact information is noted at the end of this sheet. If you are happy to participate in the study, please complete and sign both consent forms and return one copy to the researcher in the pre-paid envelope supplied. Please keep the other consent form and the information sheet for your own reference. You are under no obligation to take part in the study and are free to withdraw at any time without giving a reason.

Who is organising the study?

The study is being funded by The Stroke Association. The research team are based at the School of Health Professions & Rehabilitation Sciences at Southampton University. The team are: Fran Knapp a social science postgraduate student and Dr Rose Wiles and Professor Ann Ashburn who are supervising the study.

Who can I speak to if I want to know more?

Fran Knapp will be happy to speak to you if you need more information. Please telephone: 023 80595906 (answer-machine). The study team would like to thank you for your interest.

University
of Southampton

School of Health Professions and Rehabilitation Sciences

Professor Maureen J Simmonds, Head of School

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Email sotpadm@soton.ac.uk
Web www.sohp.soton.ac.uk/sohp/

Physiotherapist General Consent Form

Individual strategies in stroke physiotherapy treatment plans and their influence on partnership

Please initial box

1. I confirm that I have read and understand the information sheet given to me for the above study and have had the opportunity to ask questions. ☐
2. I am happy for my out-patient stroke physiotherapy treatment sessions to be observed and audio-taped and to take part in a follow-up interview after each session, which will also be audio-taped. ☐
3. I understand that all tapes and information collected and processed will be stored in a secure locked cabinet and will be kept confidential by the study team. ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

I agree to take part in this study

Name...

Work Address ....

....

Work Telephone Number ....

Signature... **Date**...............

Version 1. 19/08/03

University of Southampton

School of Health Professions and Rehabilitation Sciences

Professor Maureen J Simmonds, Head of School

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Information Sheet for Patients

How patients and therapists work together as they try to achieve their own aims in stroke physiotherapy treatment sessions

What the study is about

This research study aims to explore the ways in which patients and physiotherapists work together in stroke physiotherapy treatment sessions as they each try to achieve their own aims. It is hoped that this may lead to a better understanding of how patients and therapists interact during treatment as they each try to achieve what they want from treatment. It is also hoped that it may highlight ways to make it easier for patients and physiotherapists to talk about their own plans in treatment and how to help them to work together as partners, which may improve shared understanding and mutual satisfaction at the end of treatment.

Why have I been approached about the study?

The out-patient physiotherapists are identifying patients from the stroke physiotherapy treatment list who may be approached about the research study on the basis of specific criteria which are: being aged 65 years or over, having completed a period of in-patient physiotherapy treatment following a first stroke and currently having out-patient day hospital physiotherapy treatment.

What will happen to me if I take part?

The study will involve the researcher observing and audio-taping one of your out-patient physiotherapy treatment sessions. You will then be invited to take part in one interview which will last about 1 hour which will also be recorded on audio-tape. The interview will be held within a week of your treatment session at a time convenient to you in your own home. The researcher will contact you by telephone to make the arrangements. The physiotherapist will take part in a separate interview. The interview will involve discussion of what you felt you wanted to get from the treatment session; how you tried to achieve this; how easy you found this to do and how easy it was to share your plans with the therapist during the session.

Will my taking part be anonymous and confidential?

Your GP will be informed with your permission if you agree to take part in this research study. We will ask you for your home address and your GP's name and practice address on the consent form. The observed treatment session and the interview will both be audio-taped. Although your name may be used during the treatment session and you will be asked to give your first name at the start of the interview, this will not be used to identify any information you contribute to the study. All information from the audio-tapes and observations will be made anonymous and identified by a unique code number only. All tapes and information collected and processed will be held in a secure locked cabinet and will be kept confidential by the study team.

What should I do now?

You will have been given this information sheet by the physiotherapist, which explains about the study and what taking part would involve. A form to request more information is also enclosed. Please take these away and read them carefully in your own time. If you are happy to meet her, the researcher, who is a social science student called Fran Knapp can visit you at home to talk to you about the study and to answer any questions you may have. Please fill out the enclosed 'Preference about information' form to indicate whether you would like to meet the researcher for more information or not and return it in the post-paid envelope provided. If you want to meet the researcher, you are asked to provide your name and telephone number on the form to enable her to contact you to arrange a convenient time to visit you at home. If you then feel happy to take part in the study you will be asked to complete and sign two consent forms, one of which you will keep along with the information sheet. You are not obliged to take part in the study and are free to withdraw at any time without giving a reason. This will not affect any present or future care you may receive.

Who is organising the study?

This study is being funded by The Stroke Association. The research team are based at the School of Health Professions and Rehabilitation Sciences at Southampton University. The team are: Fran Knapp a social science postgraduate student and Dr Rose Wiles and Professor Ann Ashburn who are supervising the study.

Who can I speak to if I want to know more?

Fran Knapp will be happy to speak to you if you need more information. Please telephone: 023 80595906 (answer-machine). The study team would like to thank you for your interest.

Version 2. 23/02/04

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of Southampton

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Patients' preference about information

Re: Research study exploring how patients and therapists work together as they try to achieve their own aims in stroke physiotherapy treatment sessions.

Dear Madam or Sir,

You will have been given an information sheet on the above study which explains what the study is about and what taking part would involve. Please take this away and read it in your own time.

I would then ask you to consider whether you would like to find out more information about the study and to meet the researcher Fran Knapp who can come and speak to you in your home.

I would be grateful if you could fill out the section below to indicate whether you are interested in the study or not and return the sheet to the researcher in the post-paid envelope provided. If you are not interested in the study we will not trouble you any further.

Yours faithfully,

Fran Knapp
Research Student

Please tick the relevant box:

Yes, I am interested in the study and would like to know more ☐

Name .... Contact Telephone No. ....

No, I am not interested in taking part in the study ☐

Version 2. 23/02/04

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Patients' Consent Form

How patients and therapists work together as they try to achieve their own aims in stroke physiotherapy treatment sessions

Please initial box

1. I confirm that I have read and understand the information sheet given to me for the above study and have had the opportunity to ask questions. ☐
2. I am happy to have one of my out-patient treatment sessions observed and audio-taped and to take part in an interview to be held in my own home which will also be audio-taped. ☐
3. I understand that all tapes and information collected and processed will be stored in a secure locked cabinet and will be kept confidential by the study team. ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
5. I give permission for my GP to be informed about my participation in the study. ☐

I agree to take part in this study

Name...

Address ....

Daytime Telephone Number ....

GP Name and Address ....

....

Signature .... **Date** ....

(Version 1. 19/08/03)

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(Letter to General Practitioners)

Dr
Practice Address

Date

Dear Dr

Re: patients' name
patients' address

The above named patient has agreed to participate in my PhD research.

The study is examining the strategies that physiotherapists and patients use in the out-patient stroke physiotherapy treatment interaction as each strive to achieve their own plans in treatment and seeking to determine how this influences the development of therapeutic partnerships. The study will involve observation of one out-patient stroke physiotherapy treatment session and patients will take part in one interview in which they will be asked to discuss their own plans in the treatment session and how they sought to achieve them.

I would be happy to discuss the study with you.

The Ethics Approval number is:

Thank you for your attention.

Yours sincerely,

Fran Knapp

Version 3. 19/08/03

APPENDIX G

Semi-structured interview topic guides

Semi-structured Interview Discussion Topic Guides

Individual strategies in stroke physiotherapy treatment plans and their influence on partnership

Physiotherapist interview discussion topics

* Discussion of what you wanted to achieve in the treatment session

* What power you felt you had to achieve what you wanted and how ready you felt about using it

* What strategies you used to try to achieve what you wanted in the treatment session

* How easy it was to share these plans and strategies with the patient during the treatment session

* How involved you felt the patient was in the treatment session

Patient interview discussion topics

* What you felt you wanted to achieve in the treatment session

* How you tried to achieve what you wanted in the session and how easy you found this to do

* How easy or difficult it was to share these plans with the therapist during the treatment session

* Whether you felt it important to go along with your own or the therapist's plans in treatment and whether this was difficult or easy to do

Version 1. 07/09/03

APPENDIX H

Examples of communication resources for patient interviews

Yes	Don't know	Physio
No	What	Explain
?	Want	Stop

1 2 3 4 5 6 7 8 9 10 11 12

Months

Years

APPENDIX I

Development of analytic thematic framework
Development of charting in within-case analysis
Development of charting in cross-case analysis

Analytic Thematic Framework for 3rd Stage Case Study Analysis
Version 1. formalised: 02/08/04
Developed from: Research questions; Topic Guide; Observation Schedule and notes from early familiarisation process of CS-1 & CS-2 data sets.

Introduction

Contextual information & demographics

* Case study code
* Site code
* Data collection settings
* Participant codes
* Characteristics of participants

Notes: participant characteristics are age; gender; dress; therapist grade; duration of this treatment session; how long patient has been attending day hospital treatment.

Section One

Expressed aims in treatment session

1.1 What the therapist wanted
1.2 What the patient wanted

Notes: may be direct statements / observations or inferred from the transcripts or observations.

Section Two

Strategies used to achieve plans

2.1 What the therapist did
2.2 What the patient did
2.3 How the strategies were understood
2.4 How easily or readily the strategies were implemented

*Notes: direct statements / observations from session or inferred from transcript. Strategies interpretations to be based on the following categories the full descriptions of which are documented on attached sheet: * power in use of space; * power in use of body movement; * power in use of voice; * power in use of touch.*

Section Three

Communication of strategies and plans in treatment session

3.1 How individual strategies and plans were communicated
3.2 How easy or difficult communication was
3.3 Why this was the case

Section Four

How the therapist and patient worked together

4.1 How involved the patient was in the session
4.2 Leadership and responsibility in the session
4.3 Social aspects of the interaction session
4.4 Power orientation and implications for partnership

Notes: part 4.2 to assess how easy/difficult leadership or expertise was for the patient in the session; part 4.3 to reference researcher's impact on interaction; power orientation assessment to build upon Observation Schedule models in attached sheet: 'unilateral-competitive and bilateral-co-operative' interactions

Physiotherapy and Power – Case Study Analysis - Charting

Demographics and participant codes

Case study code: CS-3. Site code: CS-3 d 1

Participants:

CS-3 FTher: female physiotherapist aged 25 years. Physiotherapy grade: Senior II

CS-3 MPat: male patient aged 67 years

CS-3 Res: researcher

Duration of DH treatment: 7 sessions with this therapist; 4-6 months overall.	PTInt tr p26-27
When asked the pt said it was 6th session.	ptInt tr p28-29
The pt confirmed had period of in-patient therapy before DH.	ptInt tr p30
The pt confirmed was first stroke and it occurred in February 2004.	ptInt tr p34

Section 1. Expressed aims in treatment session

1.1 What the therapist wanted

	Data Source Ref.
PT began session by saying she wanted to look at pt's arm.	Obs tr p1
First 4.5 pages suggest PT wanted to assess pt's shoulder activity & pain	Obs tr p1-5
PT said she wanted to move on from shoulder to focus on pt's finger activity	Obs tr p5
PT wanted to assert responsibility in sorting out seatbelt problem	Obs tr p5
PT demonstrated again she wanted to do specific things in session	Obs tr p14
PT asserts 'our challenge' is to see if improvement in shoulder continues when pt moves it himself.	Obs tr p6
PT asserted pt had number of issues with his affected arm and outlined the plans she had for addressing these problems in the treatment session	Int tr p1
PT agreed that treatment was in 2 parts with shoulder and hand activities and described her different plans in each section of the session	Int tr p2

1.2 What the patient wanted

Initially pt seemed happy to submit to shoulder exam, to respond to PT questions and to give feedback on pain during exam	Obs tr p1- 4
However, pt also wanted to inform PT about shoulder 'clicking' at home	Obs tr p1
'Overall goal to get 100% fit again' but in session 'to achieve movements at home' and check if right or wrong and to see if have advanced.	ptInt tr p1
When asked if had different plans for the different activities in session pt related his view of therapist's goals & rationales in working on shoulder & hand. Pain control also seemed to be an important issue for the pt as he related how this lessened if PT put pressure on the shoulder.	ptInt tr p1-2

Re: hand work in therapy pt said it was advance of what he was doing before 'because it was important he was using his hand and arm again' and therapy was concentrating on these parts completely now. ptInt tr p2

When asked if his goals in treatment were the same as the PT's, the pt seemed to misunderstand and said that they had 'greatly improved' since working with (named) PT. He said how he had worked with another (male) PT but present PT gave him 'incentive to push himself' and had done a lot of work on the arm. ptInt tr p2

When asked if he had achieved what he wanted in the session the pt said that yes everytime he attended therapy he felt he'd gained more but he also felt it was not 'coming fast enough' because he was 'determined to get back right'. ptInt tr p10

When pressed to describe what he'd been aiming for and achieved in the session the pt answered 'movements with the fingers' which he couldn't do last week. ptInt tr p10-11

The pt asserted he 'felt really great' after the session as he had been able to hold the knife and fork which had been something he had practised at home. ptInt tr p12

When asked if his goals were the same as PT's the pt asserted 'oh yes' the PT was 'pleased' about his achievements but he himself was not and wanted more - to wake up and be able to use the arm again ('a miracle') but he was 'aiming for this to happen one day' and it was what he was 'trying to achieve'. ptInt tr p13-14

The pt described how some activities were 'very tiring' and 'hard' and that whilst he understood why some people 'gave up' he would never do this as he so wanted to be 'better' and to get back to his garden and other things. (2.2) ptInt tr p23-24

Going on from his description of 'partnership' in the treatment session, the pt described how he wanted to achieve more than the PT thought and although he understood that she wanted him to 'get right', he thought he 'ought to be right far quicker' than the PT expected he would be, which the pt considered a good thing as it was 'just coming along alright now. The pt asserted that he had said he would be 'perfect' in 6 months and whilst he knew he wouldn't be and couldn't speed this up, his trying things could 'definitely help to get going far quicker' than if he did nothing. ptInt tr p38

Section 2. Strategies used to achieve plans

2.1 What the therapist did

PT asked or checked that pt had brought cutlery in Obs tr p1

PT started session by stating they would look at pt's arm Obs tr p1

PT directed pt on his dress and position on bed for shoulder exam Obs tr p1

Shoulder assessment involved PT directing pt position & movement, asking pt about pain and discussing conclusions & pt's comments/concerns Obs tr 1-5

PT directs hand *treatment activity* around table ('show me your hand') Obs tr p8

PT provided explanation of how exercises were reducing hand swelling	Obs tr p5
During session PT suggested and made alterations in table height/position	Obs tr p7,10,16
PT tells pt to relax as she assesses movement activities in limb	Obs tr p18
PT tells pt what she's doing - 'just getting a feel for how you do the movement'	Obs tr p18
PT showed pt through demonstration what to practice at home and how exactly the movement should be done (or how she wanted it done?)	Obs tr p20
PT tells pt there may be 'something different to practice this week' (was this a motivation strategy?).	Obs tr p20
PT asks pt to try the practice movement she has suggested to him now and as he does this she gives supporting advice & reassurance about his concerns & difficulty in carrying out the action.	Obs tr p20-21
PT adopted social strategy to assert variation in practice activity for pt's homework which elicited a chuckle from the pt in response	Obs tr p24
In answer to pt's assertion of 'awkwardness' in a movement, the PT acknowledged that it would be harder to do and explained why and suggested he do it relaxing the shoulder girdle and doing it resting hand on the table, challenging himself to do it freely in front of him when he was ready.	Obs tr p24
Re 'strategies' PT said shoulder work she controlled more whilst hand activities were more shared & pt active (elements of 4.1; 4.2; 4.4; 2.3 here)	PTInt tr p3
When asked directly if fostering a good rapport and working relationship to achieve goals was a 'strategy' the PT agreed 'yeah...yeah' but when asked PT said this was not a conscious planned strategy but a 'natural thing' (2.3).	PTInt tr p10-11
When asked, PT agreed did not use specific strategies but noted that in treatment session she was the one who decided nature & timing of activities, however this did not conflict with pt and they used a discussed plan (4.2; 2.3)	PTInt tr p10-11

2.2 What the patient did

pt demonstrated what movement he could do with fingers	Obs tr p8
pt observed that the hand exercises were helping the swelling	Obs tr p5
pt told PT she could do more with his hand if she wanted	Obs tr p5
pt told PT during hand action assessment that she'd have to come with him everyday which elicited laughs but PT replied 'No' she wanted him to carry on as before at home.	Obs tr 18-19

The pt interrupted PT to apologise for changing position and to ask her if this was alright. Obs tr p20

In response to PT 'technique & rationale' talk about practice work, pt tells how he 'compares' the movements (with his other hand?) to help him relax as he 'does it together'. Obs tr p23

During PT 'technique & rationale' talk about home practice work, pt asserted that a certain movement was 'awkward'. Obs tr p24

In response to PT query about any questions at end of session, pt spoke up about what he had been doing at home and concerns/problems he had experienced - particularly with spoon use. The PT responded to this by asking pt to bring cutlery in next week and sweet jar too. Obs tr p28-29

During discussion of problems of using cutlery at home, pt asserted he knew what the PT wanted him to do in the hand movement and said he knew she could correct him even if he did it badly. Obs tr p29

As he answered question about his aims in session, pt said he would tell PT exercises he tried at home or anything different to her orders ('so she knows what I'm achieving') & she would say if it was okay to continue. ptInt tr p3

When asked if he did anything to help him towards his goals the pt said that whilst PT asked him to bring some cutlery in, he also brought teaspoon as he had tried at home to eat yoghurt using this which was hard but he felt the PT liked that he had tried different things - including spreading bread which he described as 'different from holding knife/fork. pt went on to self-critique his activities as helping the arm or cheating and finished with 'it is using and making your hand work'. ptInt tr p5

When asked if he did anything as the patient towards his goals the pt noted there were things the PT set out in goals and that you could come home and do nothing (he showed Fran exercise sheets) but he thought it important to do these every morning after waking. ptInt tr p6

When pressed to say what he did in the session itself to try to achieve his goals the pt asserted that he 'definitely always' tried to see how far he could move his left hand as a baseline, then moved his right hand (a strategy he said he told PT). ptInt tr p6

Despite his view that the PT was 'right' the pt said he would always try to work to achieve things in a shorter time span than the PT planned - not to diminish the PT's knowledge in any way but simply because he wanted to improve as fast as possible. (1.2) ptInt tr p16

When asked about his contribution in communicating pain or stiffness to the PT, the pt seemed to misunderstand and went on to say he thought that it was important to be able to tolerate a certain amount of pain in getting joints moving and if one were not prepared to accept this one should 'give in.' - (the pt seems to view 'giving up or giving in' harshly almost as a weakness). (2.3) ptInt tr p17

The pt asserted that if he were not sure what PT was doing he would ask because he 'wanted to understand exactly what she was trying to do.' ptInt tr p23

Unrelated to specific tx session but interesting, the pt described how he felt he had been forgotten after discharge but he 'pestered them' to get to do DH PT. ptInt tr p29

Interesting interlude as pt described how he wanted to get out of hospital and how he did this in about 4 weeks instead of staff prediction of up to 6 weeks. The pt also told of how he did things against PT plans and got shouted at but achieved something for himself in the process. ptInt tr p31

2.3 How the strategies were understood

As PT assesses pt's limb as he carries out butter spreading action, pt says she'll have to come with him (help him?) like this everyday. PT laughed then said she was assessing the 'different types of movement' and insisted she wanted pt to continue as before at home (the pt laughed in this interlude so it is not clear if he was simply jesting in saying what he did). Obs tr p18-19
pt asserts that he recognises the 'active' problem in the shoulder described by PT as feeling he is 'cheating'. Obs tr p23

pt clarified what PT had said in his own words (? thereby showing that he understood what she meant?) (eg - 'picking up' as PT talked about grasp and working on using cutlery in next session). Obs tr p29

When asked about 'strategies' PT inquired if this meant interpersonal or physiotherapy strategies and found it difficult question to answer PTInt tr p2-3

PT described the meaning of manipulation & control in shoulder activity PTInt tr p4

PT said she had always been able to address her own plans in sessions & felt 'power' was a 'difficult word' but laughingly said her power was 'good'. Fran explained use of word 'strategies' instead. PTInt tr p8

When asked if did not use clear strategies PT agreed & said it was 'more flexible and a changing plan and with pt whose plans were similar little modification of PT plans were needed. PTInt tr p9-10

When asked about easy going nature of interaction/communication PT agreed it was flexible & due to pt's easy, dynamic, motivated & motivating nature (4.3). PTInt tr p13-14

The pt said it was important to 'relate to one another' & be 'close-knit' (4.3?) ptInt tr p18-19

When quizzed about nature of control in shoulder work, PT described her treatment strategy as 'looking at fine movements of shoulder which pt can't influence himself' and pt's role as giving feedback on what PT did. PTInt tr p17

PT describes how shoulder activity was more 'therapy dependant'. PTInt tr p17-18

When asked what pt understood, PT said her shoulder treatment technique were familiar to pt from 8 weeks treatment duration & pt also knew what feedback the PT wanted from him which PT agreed shaped their interaction as she didn't have to use verbal explanation to get the input she wanted from him. PTInt tr p18-19

PT described how pt demonstration of spreading activity was him showing what he could do, the movement of which she analysed & corrected via facilitation and feedback on how movement should feel as pt was 'not always able to see the correct way to do a movement' said PT (1.1; 2.1; 3.1) PTInt tr p20

PT described how her 'demonstrating' of 'opposition' movement and facilitation showed pt how to do it as simply verbal explanation not enough (3.1) PTInt tr p21

In summary, PT again asserted she didn't go into session thinking strategies but and (general view) rapport with pt to achieve things was not analysed daily. PTInt tr p23-24

When asked if his goals related closely to PT's, pt said he had an advantage as he had trained gymnasts so knew about body movement which helped the PT as the pt easily understood things the PT said which others may not (eg 'relax arms'). ptInt tr p3

The pt went on to clarify how comparing his good hand function with his right hand function helped him see his goal to achieve with affected hand. ptInt tr p7

When asked why he demonstrated his functional abilities pt said that PT was 'trying to see how much he did at home'. The pt asserted the session itself was only 20 minutes and as this was 'not enough' he did work at home which he would show to PT to let her see what he'd achieved. He said if he didn't do this work at home he would not progress as he had. ptInt tr p7-8; 19

When asked if he used demonstration to show PT his understanding of PT goals pt said he would tell PT that he had tried something different and she would say if this was good or if it contradicted her goals. So pt related things to PT in case of doing something wrong and PT would 'no doubt put me right'. ptInt tr p8; 19

In answering query about his aims and achievements pt asserted he had been able to move his fingers BUT went on to say that this did not satisfy the PT whom he said wanted him to do it properly by touching finger tips and not sides with thumb - pt said he understood what she wanted and was trying to do it that way. ptInt tr p11

When asked if he understood the PT goals the pt said 'oh yes' and said the PT wanted it done 'perfectly' without 'cheating by lifting shoulder up' which has to 'stay relaxed' and PT would not accept 'half measures' and would say if pt did not do it right which was 'a good thing'. (3.1? - direct) ptInt tr p11-12

Whilst the pt had felt very good about achieving being able to hold the knife/fork in the session which he had been practising at home, he said that he 'had to take it again next week' as PT was going to 'show him how' although he found it difficult - here the pt is demonstrating his own perspective of treatment although he seems to understand the rationale of the PT's goals. ptInt tr p12

When asked about how he and PT communicated their goals which appeared to be quite well, the pt said the PT had all his goals set out in 3 months but that he had passed this and so the PT was 'pushing' the cutlery goals with him now. ptInt tr p12-13

The pt asserted the need to 'trust the person you're working with' as they 'know their job... and have been trained' and he trusted the PT and wanted to 'get it right'. ptInt tr p13

When asked if his goals were same as PT's the pt answered 'oh yes yes' and asserted the PT was 'pleased' with his achievement although he was not and wanted more - to wake up and find he could use the arm again completely. ptInt tr p13-14

The pt agreed that the PT's focus was on more detailed finger movements and 'touching the tips) and 'wanted it finalised and perfect' but the pt asserted he was 'happy getting fingers on the ends' (happy with own plans despite PT power?).(4.2?) ptInt tr p14

The pt asserted that he understood the PT's desire for perfect movement as it was similar to gymnast training where movement had to be 'spot on' to achieve moves. ptInt tr p15

When questioned about the strategy of contributing expressions of pain or stiffness the pt said he understood my question as relating to PT's work on the shoulder and that whilst he felt he should put up with some pain, if he said it was sore the PT would stop and 'massage & work the limb to get it moving more'. ptInt tr p17-18

When asked his view of PT tactile treatment process, pt said PT was 'warming' muscles/tendons in hands & getting them moving, which he himself 'did a lot.' ptInt tr p20-21

The pt described how PT asked him to bring in sweet jar and that his being able to get fingers round this was an 'achievement & 'what she wants to open up.' ptInt tr p19

'They know the body inside out' said pt and PT knew when shoulder/arm was 'too much forward' - pt indicates he had some insight into PT's work on shoulder & arm although he didn't know why the problem had occurred (but may relate to session other than that observed with that therapist) ptInt tr p22

When pressed about the work PT did on the shoulder in the observed session the pt related his understandings of why PT worked on shoulder and what was done with muscles, tendons & movements with particular reference to PT's knowledge ptInt tr p22-23

When asked the pt asserted he had never been embarrassed in therapy because he was not that type and hospitalisation made you lose any sensitivity to this - because 'they' see you as a 'body' said the pt 'nothing else'. (other HCP's too here) ptInt tr p25

When asked to clarify if this included PT's too, pt asserted that 'yes it's a body to them' and it could be anyone but the PT would 'work on it just the same'. ptInt tr p26

The pt described the rationale behind the end of session handshake which was a weekly thing he said. It seems that the PT insisted he use his affected hand rather than good hand which he did at first and as pt went on this was to work on grip. Fran also noted pt reached out to shake her hand when he first met her. ptInt tr p27-28

During the interview the pt sometimes generalised to events in other treatment sessions (in and out-patient) or commented on his views of the activities and motivations of other patients. To try to encourage the pt to concentrate on the events and understandings of the observed treatment session, Fran would often preface questions with a statement: 'In the treatment session I observed.....' general data

At the end of his interview, the pt described how he felt that it was funny 'this had happened' (the stroke) and that this was 'another achievement sent to his life to try sort myself out and get through it' and that it was 'another task' set him which he was going to 'sort out..get going and make sure it's right.' ptInt tr p38

The pt in summary at the end of interview said it was a pleasure talking to researcher and relaying his experiences and that whilst some people want to think it 'should not have happened to me and sit back and do nothing' but that this was not for him. (1.2; 2.2; 4.3) ptInt tr p39

2.4 How easily the strategies were implemented

PT said she had always been able to achieve what she wanted so 'power' was a difficult word to use. PTInt tr p8

PT said her managing progress of session did not conflict with pt plans as session was talked over between them and she and pt had similar goals. PTInt tr p5;12

When asked directly, PT asserted she found it 'very easy' to achieve what she wanted in session because they had 'same direction' and 'small gains each session rather than dramatic improvement'. PTInt tr p14

When asked if it was important for him to speak up about how he experienced activities and if some were difficult, the pt said that anything like that he would speak up and that the PT 'encouraged' him to do so. ptInt tr 18

When asked if he found it easy to questions things in physiotherapy the pt said he found it 'very easy'. ptInt tr p23

Section 3 Communication of strategies and plans in treatment session

3.1 How strategies and plans were communicated

PT often used an 'on-going commentary' during treatment activities involving directions, pauses, exhortation and feedback Obs tr 3,6...

pt used humour at times in responding to PT questions (eg butter comment) Obs tr 16

pt chuckles as he said things at times (?why) (eg thumb not working) Obs tr p27

pt sometimes went on to describe what he did in more detail (eg butter dish) and PT paraphrased what he said in terms of the action (shared discussion) Obs tr p17

The PT gave pt a 'technique & rationale' talk in relation to what she wanted him to practice at home and the movement she wanted to achieve using demonstration & repetition to support understanding taking the pt through the action/movement, giving feedback on performance, technique & rationale in an on-going narrative similar to that used in the *treatment activities interludes.* (instructs/explains/shows/encourages/assesses) Obs tr p21-25

PT appeared to 'summarise' her instructions to the pt about his homework for the week and goes on to emphasise by demonstration using her own hand and repetition of the goal they are specifically aiming for (opposition pad to pad). ('that's the goal and that's the goal') Obs tr p25

PT uses emphasis to illustrate what not to do during discussion of an aspect of hand function. Obs tr p26

The pt demonstrates how he has to 'straighten the finger to there' when stretching. Obs tr p26

PT assesses pt hand activity during *discussion/demonstration* of homework activity, suggesting how he might have done it better, giving praise when he achieves what the movement she wants and giving some technical detail on avoiding 'getting the trapezius muscle working' (to illustrate her point perhaps? - not sure about her motives here) Obs tr p23

3.2 Ease or difficulty of communication

When asked how well she and pt communicated about goals PT agreed this was managed quite well (although strategy communication not assessed here). PTInt tr p10

PT asserted that a 'good rapport and good working relationship' was important in the success of achieving goals. PTInt tr p10

When told that he and PT appeared to communicate well about what the were doing in session, pt said 'you've got to work with them'...and PT seemed 'keen, wanted to help and although it was her job, took her work seriously, was friendly and related well to people with a nice attitude'. (4.3) ptInt tr p9-10

Section 4. How the therapist and patient worked together

4.1 How involved the patient was

PT described how pt told about his problems at start of session and these were then addressed which indicated his 'significant power' she said laughing (2.3) PTInt tr p7

PT felt pt was 'very involved' in session. PTInt tr p15

PT described 2 therapy techniques used with pt with different control levels (motor guidance/manipulation & motor relearning) & how pt worked well in the latter which involved pt feedback & modification which helped his goals. PTInt tr p15

When asked if he felt his goals & plans were close to PT's, pt said he and PT 'worked closely together' and that this trust was essential as well as knowing that the PT 'is there to help you as much as she can' and pt wanted to get back to normal as quickly as he could. (1.2; 2.3; ?2.2) ptInt tr p4

When told that he and PT appeared to communicate well about what they were doing in the session, the pt said he felt that 'you've got to work with them' and their 'hardest job was to get you to do it at home' and if you didn't do this you were wasting everyone's time and 'might as well not bother going'. ptInt tr p9

When asked if he felt quite involved whilst the 'lead and expertise' came from the PT, the pt answered 'yes' and that he would contribute much more than the PT would expect. ptInt tr p16
When told he seemed quite involved in session & keen on pushing yourself forward & asking questions the pt agreed you 'gotta be this way all the time'. ptInt tr p32

The pt asserted that he would not let people do things for him unless he'd tried himself to do it and would accept help only if he couldn't achieve it. ptInt tr p32

The pt agreed that this was 'personal motivation' as suggested by Fran and said that you had to have this. ptInt tr p32

The pt asserted that he helped the PT in managing the equipment in the session by putting the brake on (Fran did not notice this) and said that he would try to do things such as pulling the table over...and that he saw much that went on and what PT's used and what they didn't use. ptInt tr p35-36

As he talked about how he felt able to get involved in the session, the pt said he had suggested in the session that the microphone could be put on the chair (4.2) ptInt tr p36

When asked if he felt the therapy gym was PT's area the pt asserted that he felt it was 'as much my area as hers when I go in' and that PT liked this and that he would suggest he tried using different equipment such as stress balls or yoghurt cup which he would then take in to demonstrate what he was doing at home. The pt asserted that through this the PT was 'learning & picking up tips'. (4.2; 2.3) ptInt tr p36

4.2 Leadership and responsibility in the session

PT gives Fran permission to move recorder & microphone if needed. Obs tr p7

pt told PT she could do more exercises with his hand if she wanted to. Obs tr p5

pt initiated discussion of spreading butter on bread activity at home which led to episode where he gave more detail of action and PT assessed hand & shoulder action as he carried out movement. Obs tr 16-19

pt asserted the elbow movement was the one he found difficult in PT's plans Obs tr p20

PT announced when she wanted to finish the session which pt responded with a quiet 'yes'. PT then asked if pt had any questions. Obs tr p27

PT gives pt free sanction to use 'other hand to mould movement'. Obs tr p270

In discussion about pt's concerns about his activity with cutlery at home, PT suggested he bring in cutlery & sweet jar the next week and they would maybe do some treatment that would focus more on the cutlery use & grasp. Obs tr p29

When asked PT asserted both were in charge of treatment session because of talking about goals & she & pt having 'common goals' although other pts she may have to control more. PTInt tr p4-5

PT asserted she & pt had same goals in mind so she did not have to 'steer it directly' because pt gave feedback on his problems & activities, key ones of which were then addressed. PTInt tr p6

PT felt that question of who controlled session was difficult to answer and interview involved Fran clarifying meaning & focus of questions. PTInt tr p6

PT agreed that she had to lead the session because of time constraints & need to make session efficient & effective & 'to achieve what you want'.
PT asserted that 'it was teamwork' between she and pt which developed over time but took little time between them in practise. PTInt tr p25

When asked whose plans were most important his or PT's the pt asserted that 'yes he had his own goals' which he wanted to do but that he would work on these the way 'they want me as well to do it' because it was 'important to do it right' as if the pt is not trying to do it right it will not be done properly and he himself seemed to feel it important that it was done perfectly. ptInt tr p15

When asked directly who was in charge in session, pt asserted it was PT because he had 'no doubts about her being right' and he would not go against her because 'she was trained and knew exactly' whilst he was not qualified. ptInt tr p15

The pt asserted that whilst he may have his goals/views of progress the PT would see it differently and her view would be 'right. ptInt tr p15

The pt described how he felt the tx area was as much his as PT's and how he would help to move equipment & suggested microphone could go on chair. ptInt tr p35-36

The pt went on to describe how he would suggest using different things in therapy and would take these in to show PT what he was doing at home with stress balls & yoghurt cups - and he felt the PT was 'learning & picking up tips'. Interestingly, the pt said he was not saying he was an expert but that these were things he was trying to do and that it related to how he was trying to do things with the affected hand to get it working again & that PT took notes as he did things. ptInt tr p36-37

4.3 Social aspects of the interaction session

PT used pt's first name during treatment session and in interview Obs tr; PTInt tr p1

PT asks Fran if they are speaking loud enough for her Obs tr p7
PT & Fran converse about position of recorder & microphone Obs tr p7-8
PT reacts to something pt does by laughing & calling him 'cheeky' Obs tr p7

PT and pt laugh at her telling him what she is going to do after she has done it and he has already gathered what she's doing Obs tr p17

Marked social element to the interaction which partly involved Fran too - laughter, joking about photograph, firm handshake from pt which PT complimented and confirmation of next session at same time & place. Obs tr p9-31

When asked, PT said that being taped may have made her hold back trying not to say or do some things and it may have made session slightly longer but otherwise was quite a normal session and not uncomfortable. PtInt tr p22-23

When asked about Fran's presence the pt asserted that once I'd set up and session started 'you might not have been there' and there was no pressure or embarrassment and 'normal routine' followed. The pt seemed to indicate that if he did make eye contact in session it was because of my position in front. ptInt tr p27

When told he and PT appeared to communicate well, pt asserted some interesting social observations of PT interaction with him - 'friendly manner'; 'nice attitude'; 'relates to people as if she's known them long time'. ptInt tr p9-10

The pt asserted he and the PT 'seemed to hit it off together' and had a 'friendship' relationship rather than as a 'patient'. ptInt tr p13

Following his comment about PT's seeing pts as 'bodies' the pt asserted he used social humour and jokes and talking to relax everyone and this friendly & helpful manner helped him to 'gain more out of it'. (2.2) ptInt tr p26

The pt went on to give example of how he and PT interacted as he joked about doing something wrong and PT reacted with humour too - which pt asserted was 'a relationship..bonded between one another and trust' and that he knew the PT 'had her job to do and was helping him' and that was good & 'meant a lot to him.' pt Int tr p26-27

During the pt interview Fran provided pt with some explanations of why demographic details of stroke, personal data and therapy were requested - though pt did not ask for this. This may have been due to slight embarrassment. ptInt tr p34

4.4 Implications for partnership

When asked if the way he and PT worked together in the treatment session was like a 'partnership' the pt said 'Oh every session is there' and he looked forward to seeing the PT who was 'bouncy and cheerful in her ways'. ptInt tr p37

When asked to explain how the treatment session was a 'partnership', the pt described how there was no embarrassment in what he and the PT did, that there was 'a bond' between them and 'knowing what we want and what we want to achieve' and how sometimes he would ask if the PT wanted his shirt off and how she would sometimes tell him to take it off to see his 'shoulder and bone working'. ptInt tr p37-38

Mapping key concepts of Interaction Strategies (in cross-case analytical process) to construct explanatory model of how these 'power interactions' in the stroke physiotherapy encounter are used and how this might influence/shape 'partnership working'.

Therapist use of communication interaction strategies

A. Therapist use of discussion strategies:

1. To gain information about patient's progress & problems after a period of separation in treatment. (CS-2)

2. To gain information about patient's functional progress in review session after period of group therapy. (CS-6)

3. To gain information during physical assessment about patient's problems with home activities. (CS-3)

4. To clarify questions about patient's pain during physical assessment activities. (CS-3)

5. To explain therapeutic interventions to patient/wife to involve them in treatment plans. (CS-4)

6. To force solutions to deal with patient's objections to plans to move him towards more independent with his mobility. (CS-6).

8. Therapist's use of banter in discussions to admonish and persuade patient to compliance with plans for greater independence in mobility. (CS-6).

9. Therapist use of open questions to help patient to express his views in treatment discussions. (CS-5).

10. To encourage patient to feedback to her on problems and progress as part of managing treatment plan. (CS-4).

11. Therapist's use of discussion to facilitate patient's involvement and consent to treatment in limited time session by offering him 2 choices of activity. (CS-5).

B. Therapist's use of quieter periods of interaction in treatment to facilitate joint discussion/facilitate patient participation:

1. Therapist's opportunistic use of rest periods to facilitate joint discussion interaction (possibly to facilitate patient participation) (CS-1).

2. Therapist's opportunistic use of extended seated ultrasound treatment session to maximise patient's ability to express his views in joint discussion about treatment. (CS-5).

C. Therapist's use of non-verbal communication strategies:

1. Therapist's use of eye contact to facilitate patient's communication during session. (CS-5).

2. Therapist's monitoring patient's non-verbal body language and expressions to maximise his communication in the session. (CS-5).

3. Therapist's establishment of communication strategy with patient to maximise their shared understanding during session. (CS-5).

4. Therapist's exertion of effort to make frequent eye contact during discussions when working at patient's feet to maximise their shared understanding. (CS-4).

Patient use of communication interaction strategies

A. Patient use of discussion strategies:

1. Patient use of discussion interactions to express her experiences/problems at home. (CS-1)

2. Patient use of discussion to establish date for next treatment visit. (CS-1)

3. Patient's use of discussions to express her views and questions to therapist. (CS-2)

4. Patient use of discussion with physical demonstration in treatment activities to explain innovative exercises to therapist to check their appropriateness. (CS-3)

5. Patient use of discussion to distract himself during walking activity to reduce tension-induced tone in his body. (CS-4)

6. Patient's use of discussion to argue support for his own mobility plans in opposition to therapist and wife's plans for his greater independence. (CS-6)

B. Patient use of non-verbal communication strategies:

1. Patient use of emotive facial expressions and exclamations to communicate effort and pain to therapist during treatment activities. (CS-5).

2. Patient's use of loud expressions of effort to communicate his hard work and fatigue to therapist during treatment activities. (CS-6)

Therapist use of treatment activities strategies

A. Therapist's communication strategies in treatment activities:

1. Therapist's use of verbal control narrative to control and correct patient's movements as part of her physical assessment. (CS-1; CS-3; CS-4; CS-5; CS-6)

2. Therapist's use of varying degrees of verbal control narrative to control and correct patient's movement during physical assessment. (CS-2)

3. Therapist's use of physical demonstration with own and patient's hand in association with verbal explanation to educate patient about home exercises. (CS-3)

4. Therapist's use of counting aloud strategy with patient to regulate walking pace to improve gait. (CS-4).

B. Therapist's physical control strategies

1. Therapist's use of physical guidance of patient's body to educate the patient in the therapeutic movement. (CS-1)

2. Therapist's use of passive movement of patient's shoulder as part of a physical assessment process. (CS-3)

3. Therapist's use of tactile facilitation of normal movement to educate the patient to control the movement himself. (CS-4)

4. Therapist's handling of patient's limb to assess its functional status. (CS-5)

5. Therapist's use of close physical proximity to guide and control patient's trunk movement during treatment. (CS-6)

C. Therapist's control of patient's safety

1. Therapist's use of assistant to increase supervision of patient's safety during activities. (CS-1)

2. Therapist's use of close physical proximity during activities to ensure patient safety. (CS-2; CS-6)

Patient's use of treatment activities strategies

A. Patient's expressing understanding to therapist

1. Patient's use of pretence to perpetuate therapist's belief that progress was being made in patient's education about her physical posture. (CS-2)

2. Patient's use of single word commentary during therapist's verbal control narrative to indicate understanding. (CS-5).

B. Patient's communication strategies in treatment activities:

1. Patient's use of concentration to focus on physical activity rather than talking to ensure her safety. (CS-2).

2. Patient's use of experience in gymnastics training to achieve shared communication with therapist. (CS-3).

2. Patient's avoidance of communication with therapist during periods of concentration on treatment to maintain good working relations. (ie not to appear rude) (CS-4).

C. Patient's use of motivation in treatment

1. Patient's use of experience in sports training to motivate himself in therapy. (CS-3)

Therapist's use of social interaction strategies

A. Therapist's use of social strategies to gain information

1. Therapist's use of therapy assistant's longer social association with patient to gain background information on patient. (CS-1)
2. Therapist's use of social discussion with patient to find out how he and his family were getting on at home. (CS-4; CS-5).

B. Therapist's use of humorous social interaction with patient

1. Therapist's use of humorous comments in session to try to induce light-heartedness in patient who was rather serious. (CS-2)
2. Therapist's use of humorous social interaction with patient to hide her embarrassment in being observed in session. (CS-2).
3. Therapist's use of chiding light-hearted comments to manage patient's bashful jokiness in the session. (CS-3)
4. Therapist's use of light-hearted social chat during seated ultrasound treatment perhaps to aid patient relaxation and communication with her. (CS-5)
5. Therapist's use of social banter with patient on the basis of her long association with patient's therapy, to persuade him to comply with her plans for extending his independence in mobility. (CS-6)

C. Therapist use of touch as a social strategy

1. Therapist's use of therapeutic touch to break down social barriers with patients during treatment. (CS-4).

Patient's use of social interaction strategies

A. Patients' use of social strategies to enhance or avoid social communication

1. Patient's conceptualisation of therapist as a friend who would talk and listen to her, which may have aided her communication. (CS-1)
2. Patient and wife's guardedness in social interaction with therapist to avoid disclosing too much personal information since this was not important to them. (CS-4).

B. Patient's use of social strategies to gain therapist's approval/attention

1. Patient's use of endearing chuckling manner in communication with therapist and assistant to gain sympathy and help. (CS-1)
2. Patient's use of bashful joking social interactions with therapist to express his awe of her. (CS-3)

Negotiation of leadership and participation

CS-1

1. Therapist use of professional authority to take responsibility for the plans and progress of session as patient lacked ability to do this.

2. Patient acquiescence to therapist's authority and expertise in session to enable achievement of her best in treatment.

3. Patient's avoidance of independent initiative in session because she did not want to show off or do something wrong.

CS-2

1. Therapist's use of professional authority to take leadership of the session to deal with the patient's quiet passivity and lack of initiative.

CS-3

1. Therapist's use of professional authority to lead the course of the session to ensure effective use of limited treatment time.

2. Therapist's use of a flexible team-based treatment plan in session to incorporate the patient's independent treatment activities ideas.

3. Patient's use of personal authority in the gym space to assist the therapist in moving the equipment.

CS-4

1. Therapist's use of professional authority to lead the course of the session to ensure effective use of limited treatment time and because patient lacked skills to do this.

2. Patient's acquiescence to therapist's professional authority to achieve progress in his rehabilitation.

3. Patient's compliance with therapist's home exercise regime to achieve progress in his rehabilitation.

4. Wife's use of authority as domiciliary 'colleague' of therapist to gain advice from therapist about problem in patient's home exercise regime.

CS-5

1. Therapist's use of professional authority to lead the course of the session to ensure effective use of limited treatment time.

2. Therapist's use of professional expertise to do her job as a therapist as patients expected her to do.

CS-6

1. Therapist's use of professional authority in conducting review of patient's progress to re-establish her control over his treatment which she had overall responsibility for.

2. Therapist's use of patient's wife's agenda to try to persuade patient to comply with plans for extending mobility independence at home.

3. Patient's avowal of his acquiescence with therapist's and wife's plans despite use of stubborn opposition in treatment session.

REFERENCES

Adams, N. (1994) *Communication Skills in Physiotherapist-patient Interactions.* University of Ulster: PhD Thesis unpublished

Adler, P.A. & Adler, P. (1998) Observational techniques. In: Denzin, N.K. & Lincoln, Y.S. (1998) (Eds.) *Collecting and Interpreting Qualitative Materials.* Thousand Oaks California: Sage Publications Inc.

Ainsworth-Vaughn, N. (1998) *Claiming Power in Doctor-Patient Talk.* Oxford: Oxford University Press.

Ashburn, A.; Partridge, C. & De Souza, L. (1993) Physiotherapy in the rehabilitation of stroke: a review. *Clinical Rehabilitation* 7: 337-345.

Astrom, M.; Apslund, K. & Astrom, T. (1992) Psychosocial function and life satisfaction after stroke. *Stroke* 23(4): 527-531

Atkinson, P. & Hammersley, M. (1998) Ethnography and participant observation. In: Denzin, N.K. & Lincoln, Y.S. (Eds.) (1998) *Strategies of Qualitative Inquiry.* Thousand Oaks: Sage Publications

Attride-Stirling, J. (2001) Thematic networks: an analytic tool for qualitative research. *Qualitative Research.* 1(3): 385-405

Bach-y-Rita, P. (1991) Plasticity of the nervous system: importance in medical rehabilitation. In: Kottke, F.J. & Amate, E.A. (Eds.) (1991) *Clinical Advances in Physical Medicine and Rehabilitation.* Washington: Pan American Health Organisation

Baker, S.M.; Marshak, H.H.; Rice, G.T. & Zimmerman, G.J. (2001) Patient participation in physical therapy goal setting. *Physical Therapy* 81(5): 1118-1126

Barnard, I.S. (2003) *Exploring the Older Patient/physiotherapy Clinician Relationship.* PhD Thesis. University of Southampton

Bassett, S.F. & Petrie, K.J. (1999) The effect of treatment goals on patient compliance with physiotherapy exercise programmes. *Physiotherapy* 85(3): 130-137

Beutow, S. (1998) The scope for the involvement of patients in their consultation with health professionals: rights, responsibilities and preferences of patients. *Journal of Medical Ethics* 24: 243-7

Blumer, H. (1969) *Symbolic Interactionism. Perspective and Method.* Englewood Cliffs, New Jersey: Prentice-Hall Inc

Bohannon, R.W.; Williams Andrews, A. & Smith, M.B. (1988) Rehabilitation goals of patients with hemiplegia. Brief research report. *International Journal of Rehabilitation Research* 11(2): 181-183

Boyatzis, R.E. (1998) *Transforming Qualitative Information. Thematic Analysis and Code Development.* Thousand Oaks: Sage Publications.

Britten, N. (2000) Qualitative interviews in health care research. In: Pope, C. & Mays, N. (Eds.)(2000) *Qualitative Research in Health Care.* 2nd Edition London: BMJ Books.

British Psychological Society (2000-2004) *Ethical principles for conducting research with human participants.* Available from: http://www.bps.org.uk/the-society/ethics-rules-charter-code of conduct/code-of-conduct/ethical-principles-for-conducting-research-with-human-participants.cfm. Accessed on: 24th November 2006

Bryman, A. (2001) *Social Research Methods.* Oxford: Oxford University Press

Burgess, R.G. (1993) *In the Field. An Introduction to Field Research.* London: Routledge

Bury, M. (1997) *Health and Illness in a Changing Society.* London: Routledge

Cant, R. (1997) Rehabilitation following a stroke: a participant perspective. *Disability and Rehabilitation* 19(7): 297-304

Catterall, M. & Maclaran, P. (1997). Focus Group Data and Qualitative Analysis Programs: Coding the Moving Picture as Well as the Snapshots. *SociologicalResearch Online* 2(1). Available from: http://www.socresonline.org.uk/socresoline/2/1/6.html Accessed on: 29th November 2002

Charles, C.; Whelan, T. & Gafni, A. (1999) What do we mean by partnership in making decision about treatment? *BMJ* 319: 780-2

Charon, J.M. (1992) *Symbolic Interactionism. An Introduction, an Interpretation, an Integration.* Fourth Edition. Englewood Cliffs, New Jersey: Prentice-Hall Inc

Cheung, P.P.Y. & Yam, B.M.C. (2005) Patient autonomy in physical restraint. *International Journal of Older People Nursing* 14(3a): 34-40

Clark, M. (2000) Patient and spouse perceptions of stroke and its rehabilitation. *International Journal of Rehabilitation Research* 23: 19-29

Clarke, P.J.; Black, S.E.; Badley, E.M.; Lawrence, J.M. & Williams, J.I. (1999) Handicap in stroke survivors. *Disability and Rehabilitation* 21(3): 116-123

Coffey, A. & Atkinson, P. (1996) *Making Sense of Qualitative Data. Complementary Research Strategies.* Thousand Oaks: Sage Publications.

Coleman, P.T. (2000) Power and Conflict. In: Deutsch, M. & Coleman, P.T. (Eds.) (2000) *The Handbook of Conflict Resolution.* San Fransisco: Jossey-Bass Publishers

Coleman, P.T. & Voronov, M. (2003) Power in Groups and Organisations. In: West, M.; Tjosvold, D. & Smith, K.G. (Eds) (2003) *The International Handbook of Oganisational Teamwork and Co-operative Working.* New York: John Wiley & Sons. Chapter available from: http://www.tc.edu/icccr/centerPublicaColeman.html Accessed on: 20th November 2006

Cott, C.A. (2004) Client-centred rehabilitation: client perspectives. *Disability and Rehabilitation* 26(24): 1411-1422

Cott, C. & Finch, E. (1991) Goal-setting in physical therapy practice. *Physiotherapy Canada* 43(1): 19-22

Coulter, A. (1997) Partnerships with patients: the pros and cons of shared clinical decision-making. *Journal of Health Services Research and Policy* 2: 112-21.

Coulter, A.; Entwistle, V. & Gilbert, D. (1999) Sharing decisions with patients: is the information good enough? *BMJ* 318: 318-322

Coyer, S.M. Y Gallo, A.M. (2005) Secondary analysis of data. *Journal of Pediatric Health Care* 19: 60-63

Crabtree, J.L. & Caron-Parker, L.M. (1991) Long-term care of the aged: ethical dilemmas and solutions. *The American Journal of Occupational Therapy* 45: 607-12.

(CSP - Chartered Society of Physiotherapy) (2000) *Core Standards in Physiotherapy.* Bedford Road London: Chartered Society of Physiotherapy

(CSP - Chartered Society of Physiotherapy) (2002) *Guidance for Developing Junior/senior II Rotations within a Community or Primary Care Setting.* Information Paper. Number PA52. March.

Dalley, J. & Sim, J.(2001) Nurses' perceptions of physiotherapists as rehabilitation team members. *Clinical Rehabilitation* 15: 380-389.

Davidson, I. & Waters, K. (2000) Physiotherapists working with stroke patients. A national survey. *Physiotherapy* 86(2): 69-80

Denzin, N.K. (1989) *The Research Act. A Theoretical Introduction to Sociological Methods.* Third Edition New Jersey: Prentice Hall

Denzin, N.K. (1998) The art and politics of interpretation. In: Denzin, N.K. & Lincoln, Y.S. (Eds.) (1998) *The Art of Interpretation, Evaluation and Presentation.* Thousand Oaks, California: Sage Publications.

Denzin, N.K. & Lincoln, Y.S. (1998) Entering the field of qualitative research. In: Denzin, N.K. & Lincoln, Y.S. (Eds.) (1998) *Strategies of Qualitative Inquiry.* Thousand Oaks, California: Sage Publications.

Denzin, N.K. (2002) The interpretive process. In: Huberman, A.M. & Miles, M.B. (Eds.) (2002) *The Qualitative Researcher's Companion.* Thousand Oaks, California: Sage Publications.

Department of Health (2001a) *The Expert Patient: A New Approach to Chronic Disease Management for the 21rst Century.* London: Crown Copyright. Available from: www.dh.gov.uk Accessed on: 8th November 2006

Department of Health (2003) *Strengthening Accountability. Involving Patients and the Public.* Policy Guidance. Section 11 of the Health and Social Care Act 2001. London: Crown Copyright. Available from: http://dh.gov.uk Accessed on: 8th November 2006

Department of Health (2005), *Reducing Brain Damage: Faster Access to Better Stroke Care.* Report by the Comptroller and Auditor General HC 452 Session 2005-2006, 16th November 2005

Deutsch, M. (2000) Co-operation and competition. In: Deutsch, M. & Coleman, P.T. (Eds.) (2000) *The Handbook of Conflict Resolution.* San Francisco: Jossey-Bass Publishers

Doolittle, N.D. (1992) The experience of recovery following lacunar stroke. *Rehabilitation Nursing* 17(3): 122-125.

Drew, P. Chatwin, J. & Collins, S. (2001) Conversation analysis: a method for research into interactions between patients and health-care professionals. *Health Expectations* 4: 58-70

Edwards, S. (2002) Abnormal tone and movement as a result of neurological impairment: considerations for treatment. In: Edwards, S. (Ed.) (2002) *Neurological Physiotherapy.* Second Edition. Edinburgh: Churchill Livingstone

Eisenhardt, K.M. (2002) Building theories from case study research. In: Huberman, A.M. & Miles, M.B. (Eds.) (2002) *The Qualitative Researcher's Companion.* Thousand Oaks, California: Sage Publications

Elliott, R.; Barber, N. & Noyce, P. (2003) Can Britain and the United States learn anything from each other? *The Pharmaceutical Journal* 271: 508-510

Elsworth, J.D.; Marks, J.A.; McGrath, J.R. & Wade, D.T. (1999) An audit of goal planning in rehabilitation. *Topics in Stroke Rehabilitation* 6(2): 51-61

Feste, C. (1992) A practical look at patient empowerment. *Diabetes Care* 15(7): 922-5

Fleming, B & Golding, L. (undated) *Using Focus Groups. A Practical Guide.* Soundings Research. Kingstone, Hertfordshire

Fontana, A. & Frey, J.H. (1998) Interviewing. The art of science. In: Denzin, N.K.& Lincoln, Y.S. (1998) (Eds.) *Collecting and Interpreting Qualitative Materials.* Thousand Oaks California: Sage Publications Inc.

Forster, A. & Young, J. (2002) *The Clinical and Cost Effectiveness of Physiotherapy in the Management of Elderly People Following a Stroke.* Evidence Briefing. London: The Chartered Society of Physiotherapy

Foucault, M (1973) *The Birth of the Clinic.* London: Routledge Classics.

Foucault, M. (1982) The subject and power. In: Dreyfus, H. (1982) *Michel Foucault: Beyond Structuralism and Hermeneutics.* Chicago: University of Chicago Press

Foucault, M. (1988) On power. In: Kritzman, L.D. (Ed.) *Foucault, M.: Politics, Philosophy and Culture. Interviews & Other Writings 1977-84.* New York: Routledge

Gallop, R. (1998) Abuse of power in the nurse-client relationship. *Nursing Standard* 12(37): 43-47

Gergen, K.J. (2001) *Social Construction in Context.* London: Sage Publications Ltd

Gherardi, S. & Turner, B. (2002) Real men don't collect soft data. In: Huberman, A.M. & Miles, M.B. (Eds.) *The Qualitative Researcher's Companion.* Thousand Oaks California: Sage Publications

Glaser, B. (1978) *Theoretical Sensitivity. Advances in the Methodology of Grounded Theory.* California: The Sociology Press.

Glaser, B.G. & Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research.* New York: Aldine de Gruyter.

Giddens, A. (1993) *Sociology.* 2nd Edition. Cambridge: Polity Press.

Greenwell, J. (1996) Sociology of the NHS: when does the community decide? In: Perry A. (Ed.) (1996) *Sociology. Insights in Health Care.* London: Arnold

Haas, J. (1995) Ethical considerations of goal-setting for patient care in rehabilitation medicine. *American Journal of Physical Medicine and Rehabilitation* 74(1): S16-S20

Haffsteinsdottir, T.B. & Grypdonck, M (1997) Being a stroke patient: a review of the literature. *Journal of Advanced Nursing* 26: 580-588.

Hargie, O. & Dickson, D. (2004) *Skilled Interpersonal Communication. Research, Theory and Practice.* London: Routledge

Hanger, H.C.; Walker, G.; Paterson, L.A.; McBride, S. & Sainsbury, R. (1998) What do patients and their carers want to know about stroke? A two-year follow-up study. *Clinical Rehabilitation* 12: 45-52.

Harrison, K. & Williams, S. (2000) Exploring the power balance in physiotherapy. *British Journal of Therapy and Rehabilitation* 7(8): 355-361.

Henderson, A. (1994) Power and knowledge in nursing practice: the contribution of Foucault. *Journal of Advanced Nursing* 20: 935-939.

High, S. (2000) *Organizing and conducting focus groups.* Course booklet of a workshop presented at the Psychology Department at Southampton University on 20th March 2000.

Hildick-Smith, M. (2000) *Medical aspects of stroke.* In: Fawcus, R. (Ed.). (2000) *Stroke Rehabilitation. A Collaborative Approach.* Oxford: Blackwell Science

Hinde, A. (1991) Secondary Analysis. In: Allan, G. & Skinner, C. (Eds.) (1991) *Handbook for Research Students in the Social Sciences*. London: The Falmer Press

Hoffman, J.E. (1974) "Nothing can be done": social dimensions of the treatment of stroke patients in a general hospital. *Urban Life and Culture* 3(1): 50-70

Holstein, J.A. & Gubrium, J.F. (1998) Phenomenology, ethnomethodology and interpretative practice. In: Denzin, N.K. & Lincoln, Y.S. (Eds.) (1998) *Strategies of Qualitative Inquiry.* Thousand Oaks: Sage Publications

Huberman, A.M. & Miles, M.B. (1994) Data management and analysis methods. In: Denzin, N.K. & Lincoln, Y.S. (Eds.).(1994) *Handbook of Qualitative Research.* Thousand Oaks: Sage Publications

Hyde, K.F. (2000) Recognising deductive processes in qualitative research. *Qualitative Market Research: an international journal* 3(2): 82-90

Janesick, V.J. (1998). The dance of qualitative research design: metaphor, methodolatry, and meaning. In: Denzin, N.K. & Lincoln, Y.S. (Eds.) (1998) *Strategies of Qualitative Inquiry.* Thousand Oaks, California: Sage Publications.

Johnston, M.; Gilbert, P.; Partridge, C. & Collins, J. (1992) Changing perceived control in patients with physical disabilities: an intervention study with patients receiving rehabilitation. *British Journal of Clinical Psychology* 31: 89-94.

Jones, C. (1991) Qualitative interviewing. In: Allan, G. & Skinner, C. (Eds.) (1991) *Handbook for Research Students in the Social Sciences.* London: The Falmer Press.

Jones, M.; O'Neill, P.; Waterman, H. & Webb, C. (1997) Building a relationship: communications and relationships between staff and stroke patients on a rehabilitation ward. *Journal of Advanced Nursing* 26: 101-10.

Jones, F. & Partridge, C. (2000) Who's in control after a stroke? Do we disempower our patients? *Physiotherapy Research International* 5(4): 249-253.

Keen, J. & Packwood, T. (2000) Using case studies in health services and policy research. In: Pope, C. & Mays, M. (Eds.) (2000) *Qualitative Research in Health Care.* Second Edition. London: BMJ Books.

Kelder, J-A. (2005) Using someone else's data: problems, pragmatics and provisions. *Forum Qualitative Social Research* 6(1) 39 [Online]. Available from: www.qualitative-research.net/fqs-texte/1-05/05-1-39-e.pdf Accessed on: 8th November 2006.

Khaw, K.T. (1996) Epidemiology of stroke. *Journal of Neurology and Psychiatry* 61: 333-338

Kitzinger, J. (2000) Focus groups with users and providers of health care. In: Pope, C. & Mays, N. (Eds.) (2000) *Qualitative Research in Health Care.* 2nd Edition. London: BMJ Books

Koch, T. (2006) Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* 53(1): 91-103 (30th Anniversary Issue)

Kwakkel, G.; Kollen, B.J. & Wagenaar, R.C. (1999) Therapy impact on functional recovery in stroke rehabilitation. *Physiotherapy* 85: 377-391

Laidler, P. (2000) Enable or disable: evidence-based clinical problem-solving. In: Fawcus, R. (Ed.) (2000) *Stroke Rehabilitation. A Collaborative Approach.* Oxford: Blackwell Science

Law, M.; Baptiste, S. & Mills, J. (1995) Client-centred practice: what does it mean and does it make a difference? *Canadian Journal of Occupational Therapy* 62(5): 250-7

Lennon, S.; Baxter, D. & Ashburn, A. (2001) Physiotherapy based on the Bobath concept in stroke rehabilitation: a survey within the UK. *Disability and Rehabilitation* 23(6): 254-262.

Lennon, S. & Hastings, M. (1996) Key physiotherapy indicators for quality of stroke care. *Physiotherapy* 82(12): 655-664

Lettinga, A.T. (2002) Diversity in neurological physiotherapy: a content analysis of the Brunnstrom/Bobath controversy *Advances in Physiotherapy* 4: 23-36

Ley, P. (1988) *Communicating with Patients. Improving Communication, Satisfaction and Compliance.* Psychology & Medicine Series. London: Crook Helm

Lincoln, Y.S. & Guba, E.G. (1985) *Naturalistic Inquiry* Newbury Park California: Sage Publications Inc

Lincoln, Y.S. & Guba, E.C. (2002) Judging the quality of case study reports. In: Huberman, A.M. & Miles, M. (2002) (Eds.) *The Qualitative Research Companion.* Thousand Oaks California: Sage Publications Inc.

Lloyd, C. & Maas, F. (1991) The therapeutic relationship. *British Journal of Occupational Therapy* 54(3): 111-113.

Lui, M. & MacKenzie, A. (1999) Chinese elderly patients' perceptions of their rehabilitation needs following a stroke. *Journal of Advanced Nursing* 30(2): 391-400

Lukes, S. (1986) Introduction. In: Lukes, S. (1986) (Ed) *Power.* Oxford: Basil Blackwell Ltd.

Lukes, S. (2002) Power and agency. Review article. *British Journal of Sociology* 53 (3): 491-496

MacDougall, C. & Fudge, E. (2001) Planning and recruiting the sample for focus groups and in-depth interviews. *Qualitative Health Research* 11(1): 117-126

Maclean, N.; Pound, P.; Wolfe, C. & Rudd, A. (2000) Qualitative analysis of stroke patients' motivation for rehabilitation. *BMJ* 321: 1051-1054.

MacWhannell, D. (1992) Communication in physiotherapy practice. In: French, S. (Ed.) (1997) *Physiotherapy. A Psychosocial Approach.* Oxford: Butterworth-Heinemann

Mc Grath, J. & Davis, A.M. (1992). Rehabilitation: where are we going and how do we get there? *Clinical Rehabilitation* 6: 225-235

McIntosh, P. (2002) Issues of client examination: an imposition of power? *Nursing and Residential Care* 5(1): 36-38

Mason, J. (1996).*Qualitative Researching.* London: Sage Publications.

Mayo, N.E.; Wood-Dauphinee, S.; Ahmed, S.; Gordon, C.; Higgins, J.; McEwen, S. & Salbach, N. (1999) Disablement following stroke. *Disability and Rehabilitation* 21(5/6) 258-268

Mays, N. & Pope, C. (1995) Qualitative Research: Rigour and qualitative research. *BMJ* 311: 109-112

Mays, N. & Pope, C (2000) Assessing quality in qualitative research. *BMJ* 320: 50-52

Miles, M.B. & Huberman, A.M.(1994) *Qualitative Data Analysis. An Expanded Sourcebook.* Second Edition Thousand Oaks: Sage Publications

Millward, L.J. (1995) Focus groups. In: Breakwell, G.M.; Hammond, S. & Fife-Shaw, C. (Eds.) (1995) *Research Methods in Psychology.* London: Sage Publications.

Mott, S.; Poole, J. & Kenrick, M. (2005) Physical and chemical restraints in acute care: Their potential impact on the rehabilitation of older people. *International Journal of Nursing Practice* 11: 95-101

National Centre for Social Research (undated) *Research Techniques & Approach.* Available from: http://www.natcen.ac.uk/units/qru/qru_techniques.htm. Accessed on: 10th March 2003

National Statistics, (2001) Stroke incidence and risk factors in a population-based prospective cohort study. *Health Statistics Quarterly* 12 (Winter): 18-26

National Statistics, (2002). Annual update: 2000 mortality statistics: cause (England and Wales). *Health Statistics Quarterly* 13 (Spring): 68-70

Nilsson, L. & Nordholm, L. (1992) Physical therapy in stroke rehabilitation: bases for swedish physiotherapists' choice of treatment. *Physiotherapy Theory and Practice* 8: 49-55

O'Boyle, D.(undated) *NHS Service Delivery and Organisation R&D Programme. Programme of Research on Patient and Carer Centred Services. Concordance, Adherence and Compliance in Medicine Taking Scoping Exercise.* Available from: http://www.sdo.lshtm.ac.uk/sdo762004.html (Commissioning brief link). Accessed on: 8th November 2006

O'Brien, J.P. & Draycott, V. (1984) Spinal deformities. In: Downie, P.A. (Ed.) (1984) *Cash's Textbook of Orthopaedics and Rheumatology for Physiotherapists.* London: Faber and Faber

Palviainen, P.; Hietala, M.;Rouitasalo, P.; Souminen, T. & Hupli, M. (2003) Do nurses exercise power in basic care situations? *Nursing Ethics* 10(3): 269-280

Parry, R.H.(2001) *Communication Between Stroke Patients and Physiotherapists.* PhD Thesis, University of Nottingham

Parry, R.H. (2004) Communication during goal-setting in physiotherapy treatment sessions. *Clinical Rehabilitation* 18: 668-682

Parsons, T. (1986) Power and the social system. In: Lukes, S. (1986) (Ed) *Power.* Oxford: Basil Blackwell Ltd

Partridge, C.J.; Morris, L.W. & Edwards, M.S. (1993) Recovery from physical disability after stroke: profiles of different levels of starting severity. *Clinical Rehabilitation* 7: 210-217.

Payton, O.D.; Nelson, C.E. & St.Clair Hobbs, M. (1998) Physical therapy patients' perceptions of their relationships with health care professionals. *Physiotherapy Theory and Practice* 14: 211-21.

Philpin, S.M.; Jordan, S.E. & Warring, J. (2005) Giving people a voice: reflections on conducting interviews with participants experiencing communication impairment. *Journal of Advanced Nursing* 50(3): 299-306

Playford, E.; Dawson, L.; Limbert, V.; Smith, M.; Ward, C.D. & Wells, R. (2000). Goal-setting in rehabilitation: report of a workshop to explore professionals' perceptions of goal-setting. *Clinical Rehabilitation* 14: 491-496

Pole, C. & Lampard, R. (2002). *Practical Social Observation. Qualitative and Quantitative Methods in Social Research.* Harlow England: Prentice Hall

Poore, S. (2000) *Ethnomethodology - An Introduction.* Available from: http://www.hewett.norfolk.sch.uk/curric.soc.ethno/intro/htm Accessed on: 24th March 2004

Pope, C. & Mays, N. (2000) Qualitative methods in health research. In: Pope, C. & Mays, N, (Eds.) (2000) *Qualitative Research in Health Care.* 2nd Edition. London: BMJ Books.

Pound, P.; Bury, M.; Gompertz, P. & Ebrahim, S. (1994a) Views of survivors of stroke on benefits of physiotherapy. *Quality in Health Care* 3: 69-74.

Pound, P.; Gompertz, P. & Ebrahim, S. (1994b) Patients' satisfaction with stroke services. *Clinical Rehabilitation* 8: 7-17.

Prior, L. (2003) Belief, knowledge and expertise: the emergence of the lay expert in medical sociology. *Sociology of Health & Illness* 25 (Silver Anniversary Issue): 41-57

Quill, T.E. (1983) Partnerships in patient care: A contractual approach. *Annals of Internal Medicine* 98: 228-234.

Riddoch, M.J.; Humphreys, G.W. & Bateman, A. (1995) Stroke. Issues in recovery and rehabilitation. *Physiotherapy* 81(11): 689-694

Ritchie, J. & Spencer, L. (1994) Qualitative data analysis for applied policy research. In: Brym, A. & Burgess, R.G. (Eds.) (1994) *Analyzing Qualitative Data.* London: Routledge

Roberts, P. (1994) Theoretical models of physiotherapy. *Physiotherapy* 80(6): 361-367

Robson, J. (2002) How concordance challenges us to rethink our attitudes. *The Pharmaceutical Journal* 9(3): 836

Rose, N. & Miller, P. (1992) Political power beyond the state: problematics of government. *The British Journal of Sociology* 43(2): 173-205

Rudd, A.; Goldacre, M.; Amess, M.; Fletcher, J.; Wilkinson, E.; Mason, A.; Fairfield, G.; Eastwood, A.; Cleary, R. and Cole, J. (Eds.) (1999) *Health Outcome Indicators: Stroke. Report of a working group to the Department of Health.* Oxford: National Centre for Health Outcomes Development

Ryan, G.W. & Bernard, H.R. (2000) Data management and analysis methods. In: Denzin, N.K. & Lincoln, Y.S. (Eds.) (2000). *Handbook of Qualitative Research.* 2nd Edition. Thousand Oaks, California: Sage Publications.

Sackley, C.M. & Lincoln, N.B. (1996) Physiotherapy treatment for stroke patients: a survey of current practice. *Physiotherapy Theory and Practice* 12: 87-96

Saltman, R.B. (1994) Patient choice and patient empowerment in Northern European health systems: A conceptual framework. *International Journal of Health Services* 24: 201-29

Samuelsson, M.; Soderfeldt, B. & Olsson, G.B. (1996) Functional outcome in patients with lacunar infarction. *Stroke* 27(5): 842-846

Schut, H.A. & Stam, H.J. (1994) Goals in rehabilitation teamwork. *Disability and Rehabilitation* 16(4): 223-226

Schwandt, T.A. (1997) *Qualitative Inquiry. A Dictionary of Terms.* Thousand Oaks California: Sage Publications

Schwandt, T.A. (2003) Interpretavism, hermaneutics and social constructionism. In: Denzin, N.K. & Lincoln, Y.S. (2003) *The Landscape of Qualitative Research. Theories and Issues.* 2nd Edition. Thousand Oaks: Sage Publications Inc

Seale, J. & Barnard, S. (1998) *Therapy Research. Processes and Practicalities.* Oxford: Butterworth-Heinemann

Seidel, J. (1998) *The Ethnograph v5.0. A User's Guide.* London: Scolari, Sage Publications Software, Ltd.

'Shahar, E.; McGovern, P.G.; Sprafka, J.M.; Pankow, J.S.; Doliszny, K.M.; Leupker, R.V. & Blackburn, H. (1995) Improved survival of stroke patients during the 1980's. The Minnesota stroke survey. *Stroke* 26: 1-6

Shapero Sabari, J.; Meisler, J. & Silver, E. (2000) Reflection upon rehabilitation by members of a community based stroke club. *Disability and Rehabilitation* 22(7): 330-336

Silverman, D. (2000) *Doing Qualitative Research. A Practical Handbook.* London: Sage Publications.

Sim, J. (1997) *Ethical Decision Making in Therapy Practice.* Oxford: Butterworth-Heinemann.

Smith, E.R. & Mackie, D.M. (1995) *Social Psychology.* New York: Worth Publishers

Stacey, M. (1988) *Sociology of Health and Healing: A Textbook.* London: Routledge

Stachura, K. (1994) Professional dilemmas facing physiotherapists. *Physiotherapy* 80(6): 357-366

Stake, R. (1998) Case studies. In: Denzin, N.K. & Lincoln, Y.S. (Eds.) (1998) *Strategies of Qualitative Inquiry.* Thousand Oaks: Sage Publications

Stake, R. E. (2000) Case studies. In: Denzin, N.K. & Lincoln, Y.S. (2000) (Eds) *Handbook of Qualitative Research* 2nd Edition, Thousand Oaks: Sage Publications Inc

Stenmar, L. & Nordholm, L.A. (1994) Swedish physical therapists' beliefs on what makes therapy work. *Physical Therapy* 74(11): 1034-1039

Strauss, A. & Corbin, J. (1990) *Basics of Qualitative Research. Grounded Theory Procedures and Techniques.* Newbury Park, California: Sage Publications Inc.

Swain, J. (1997) Interpersonal communication. In: French, S. (Ed.) (1997) *Physiotherapy. A Psychosocial Approach.* Second Edition. Oxford: Butterworth-Heinemann.

Tagliacozzo, D.L & Mauksch, H.O. (1972) The patient's view of the patient's role. In: Jaco, E.G. (Ed.) *Patients, Physicians and Illness. A Sourcebook in Behavioural Science and Health. Part II* New York: The Free Press

Talvitie, U. (1996) Guidance strategies and motor modelling in physiotherapy. *Physiotherapy Theory and Practice* 12: 49-60

Talvitie, U. & Reunanen, M. (2002) Interaction between physiotherapists and patients in stroke treatment. *Physiotherapy* 88: 77-88

Tang, S.Y.S. & Anderson, J.M. (1999) Human agency and the process of healing: lessons learned from women living with a chronic illness – 're-writing the expert'. *Nursing Inquiry* 6: 83-93.

Tennant, A.; Geddes, J.M.L.; Fear, J.; Hillman, M. & Chamberlain, M.A. (1997) Outcome following stroke. *Disability and Rehabilitation* 19(7): 278-284

Thelan, L.A.; Davie, J.K.; Urden, L.D. & lough, M.E. (1994) *Critical Care Nursing. Diagnosis and Management.* St Louis: Moseby

The Stroke Association (undated). *Physiotherapy and Strokes Leaflet.* London: The Stroke Association.

Thomas, C. & Parry, A. (1996) Research on users' views about stroke services: towards an empowerment research paradigm or more of the same? *Physiotherapy* 82(1): 6-12

Tomalin, C. (2003) *Samuel Pepys. The Unequalled Self.* London: Penguin Books.

Twining, C. (1988) *Helping Older People. A Psychological Approach.* Chichester: John Wiley & Sons

Tyson, S.F. (1995) Stroke rehabilitation: what is the point? *Physiotherapy* 81(8): 430-432

University of Southampton Regulations for Higher Degrees 2005/2006 (11 July 2005)

van den Berg, H. (2005) Reanalyzing qualitative interviews from different angles: the risk of decontextualization and other problems of sharing qualitative data. *Forum Qualitative Social Research* 6(1) 30 [Online] Available from: www.qualitative-research.net/fqs-texte/1-05/05-1-30-e.pdf Accessed on: 8th November 2006

van Gijn, J. & Dennis, M.S. (1998) Issues and answers in stroke care. *The Lancet* 352(suppl. II): 23-27.

van Vliet, P.M.; Lincoln, N.B. & Robinson, E. (2001) Comparison of the content of two physiotherapy approaches for stroke. *Clinical Rehabilitation* 15: 398-414.

Wade, D.T. (1999a) Goal planning in stroke rehabilitation: why? *Topics in Stroke Rehabilitation* 6(2): 1-7

Wade, D.T. (1999b) Goal planning in stroke rehabilitation: what? *Topics in Stroke Rehabilitation* 6(2): 8-15

Waterworth, S. & Luker, K.A. (1990) Reluctant collaborators: do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing* 15(8): 971-6

Wellwood, I.; Dennis, M.S. & Warlow, C.P. (1994) Perceptions and knowledge of stroke among surviving patients with stroke and their carers. *Age and Ageing* 23: 293-298

Wiles, R.; Pain, H.; Buckland, S. & McLellan, L. (1998) Providing appropriate information to patients and carers following a stroke. *Journal of Advanced Nursing* 28(4): 794-801

Wiles, R.; Ashburn, A.; Payne, S. & Murphy, C. (2002) Patients' expectations of recovery following stroke: a qualitative study. *Disability and Rehabilitation* 24(16): 841-850

Wilson, P.M. (2001) A policy analysis of the expert patient in the United Kingdom: self-care as an expression of pastoral power? *Health & Social Care in the Community* 9(3): 134-142

Wood, P.M. (1984) Principles of treatment following joint examination and assessment. In: Downie, P.A. (Ed.) (1984) *Cash's Textbook of Orthopaedics and Rheumatology for Physiotherapists.* London: Faber and Faber

Williams, S. & Harrison, K. (1999) Physiotherapeutic interactions: A review of the power dynamic. *Physical Therapy Review* 4: 37-50

Yin, R.K. (2003) *Case Study Research. Design and Methods.* Third Edition. Thousand Oaks: Sage Publications