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## Learning Physiotherapy: Physiotherapy students' ways of experiencing the patient encounter

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#### **ABSTRACT**

**Background:** The aim of the present paper is to describe and analyse the impact of formal education and professional experience on physiotherapy students' ways of experiencing the *Interaction* within a patient encounter. **Methods:** Two groups of physiotherapy students were interviewed on two occasions; during the second and last term of the formal programme and during the last term and after 18 months of professional experience respectively. Data were subjected to a qualitative analysis. Changes in conceptions between the two interview occasions were described quantitatively.

**Results:** The subjects' ways of experiencing the *Interaction* within a patient encounter could be described in four main categories; *Mutuality*, *Technicalism*, *Authority* and *Juxtaposition*. *Mutuality* and *Technicalism* denoted an integration of the communicative and problem-solving processes involved in the encounter, the former category from a patient-centred and the latter from a physiotherapist-centred perspective. *Authority* and *Juxtaposition* denoted a separation of the processes, the former from a physiotherapist-centred perspective and the latter from a patient-centred perspective.

**Conclusions:** The results show a trend as regards direction of change in conceptions from separated to integrated perspectives on the communicative and

problem-solving processes after the formal educational programme. After 18 months of professional practice, the *Mutuality* category dominated.

**Key words:** Physiotherapy, learning, interaction, conceptions, qualitative analysis, contextual analysis, phenomenography

#### **INTRODUCTION**

The interaction between physiotherapist and patient is an important part of the physiotherapy treatment and, thus, also an important part of the physiotherapist's professional competence. Tyni-Lenne' (1987) suggested that the physiotherapy process could be described as the integration between the processes of problem-solving, decision-making and interaction.

Studies of physiotherapy praxis according to an *expert-novice* paradigm comprise descriptive studies of the variations between expert or master clinicians and novice physiotherapists as regards their work within different clinical settings, and how the development of expertise in physiotherapy is constituted (Jensen, Shepard, & Hack, 1990; Shepard & Jensen, 1990; Jensen, Shepard, Gwyer, & Hack, 1992; Martin, Thornberg, & Shepard, 1993; Shepard, 1993). Findings from these studies show e.g. that expert physiotherapists focus on the patients' verbal as well as non-verbal communication in the patient encounter, while novices use a medley of approaches for gathering data and maintaining report (Jensen *et al*, 1992).

Interaction has also been focused in several empirical studies, pertaining to what could be labelled a *communicative perspective* of physiotherapy praxis during recent years. This research perspective aims at articulating the socially and professionally constructed basis on which therapies are chosen and co-operation is

built (Engelsrud, 1990; Thornquist, 1992; Thornquist, 1994a; Thornquist, 1994b). The focus of the communicative research is, thus, different from studies within what could be described as a *cognitive perspective*, where the target of inquiry is how physiotherapists go about in their diagnostic thinking or clinical reasoning. From a physiotherapeutic point of view, it has been suggested that physiotherapists adopt clinical reasoning processes similar to those of their medical counterparts (Payton, 1985; Dennis & May, 1987; Thomas-Edding, 1987), but it has also been argued that physiotherapy actually places grater emphasis on treatment and subsequent evaluation than the medical models which emphasise diagnosis (Higgs, 1992.). Thornquist (1994) proposes that attention should not be restricted to either clinical reasoning or communication but, instead, be directed towards the relationship between communication and clinical reasoning in order to understand how a health problem is defined. Thornquist, based on an empirical study or physiotherapist/patient encounters, suggests the existence of different frames of reference for physiotherapeutic intervention.

A *dualistic* frame of reference was identified where the diagnostic interest comprised joint mobility from a biomechanical perspective. Characteristic of the interactive process was that the physiotherapist imposed her perspective on the patient, neglecting non-verbal body language, and thereby restricting the course of interaction.

A *phenomenological* perspective of the patient as an embodied subject, regarding the body as an expression of the person's life and history was also discerned as a frame of reference. The initiative in the encounter shifted between the physiotherapist and the patient respectively. The physiotherapist had an accepting attitude towards body language from the patient and this was integrated in the process, thus opening and expanding the course of interaction.

A field study of physiotherapists working in primary health care showed similar results (Abrandt, 1996). Two physiotherapists' encounters with a total of 15 patients were observed. Two perspectives of the physiotherapists' relationships to patients were discerned; a dualistic and medical, organ-oriented and a dialectic, interaction-oriented perspective, respectively.

Similar results were also obtained by Westman-Kumlien & Kroksmark (1992), who showed in a study of first encounters between 10 physiotherapists and their patients that two main perspectives of the therapeutic relationships dominated among the physiotherapists. 1) The relationship was based on a dialogue aimed at discovering the patient's own conceptions of his/her problems and strategies to solve them and 2) the relationship was not based on a dialogue, but the physiotherapist perceived herself as the authority. Findings that point out the authoritative role of the physiotherapist were also obtained in Engelsrud's (ibid.) and Ek's (1990) studies of physiotherapy treatment sessions.

The importance of developing communicative skills has also been recognised within several physiotherapy training programmes in Sweden. At the Faculty of Health Sciences in Linkoping, interaction has also achieved status as an overarching concept, central and instrumental to other core concepts within physiotherapy. Problem-based learning (PBL) is the common pedagogical approach for all study programmes provided. (Kjellgren et al 1993). The implementation of PBL has consequenses for the organisation of the physiotherapy curriculum. In PBL, real-life situations are taken as a point of departure for the learning. This requires an alternative organisation of the curriculum, since what appears as a problem, an event or a phenomenon in real life is seldom disciplinary but rather thematically organsised. The principle of thematic organisation is therefore a characteristic feature of the curricula at the Faculty of Health Sciences. The structure and content of the physiotherapy curriculum are based on the concepts of Movement, Health and Interaction, all considered central to physiotherapy. The intended curriculum is one way of describing what is conveyed by means of the formal education. At the same time, it is insufficient to provide an understanding of the attained curriculum. The attained curriculum refers in this case to the impact of the education in terms of how the basic concepts of physiotherapy are actually conceived of by the students. In this respect, we also know little about the

professional work and its impact on the newly graduated physiotherapists' conceptions of the core concepts within the profession.

*Aims of the study* 

The scope of the present study is the impact of formal education and working-life experience on the development of professional competence in physiotherapy. This is delimited to certain aspects, namely, the students' and later on physiotherapists' ways of experiencing the patient encounter.

#### RESEARCH PERSPECTIVE AND METHOD

Phenomenography

The study is conducted within a phenomenographic framework. Phenomenography is a research approach which was developed by Marton, Saljo, Dahlgren, and Svensson at the University of Gothenburg in a series of studies of learning in higher education carried out in the early 1970s. A basic assumption is that individuals vary with regard to how they understand different phenomena in the surrounding world (Marton 1981). The aim of the analysis is to arrive at a description of similarities and differences concerning how a certain phenomenon is actually conceived of by people (Marton, 1981; Dahlgren & Fallsberg, 1991).

#### Contextual analysis

An experience or a conception of a phenomenon, i.e. the internal relation between subject and object, could also be described as a way of delimiting an object from its context and relating it to the same or other contexts, and as a way of discerning components of a phenomenon and relating these parts to each other and to the whole entity of the phenomenon. Svensson (1985) has described this approach as contextual analysis. The results of a contextual analysis is a combination of explorative and interpreting features on the one hand, and analytic features on the other hand (Svensson, 1989).

#### THE EMPIRICAL STUDY

Design

The study comprises two cohorts of physiotherapy students at the Faculty of Health Sciences in Linköping, the spring cohort -91 and the autumn cohort -92, each group comprising 18 students. The students in  $group\ I$  (autumn cohort -92) were interviewed at the second and last term of the physiotherapy programme. 14 students participated in both interviews, 12 females and 2 males. The students in  $group\ II$  (spring cohort -91) were interviewed the first time at the end of the last term (T5). The second interview was conducted after they had spent 18 months as clinical practitioners (PT:s). 16 students participated in both interviews, 12 females and 4 males.

#### Data collection

Data was collected via semi-structured interviews. The starting point of the interviews was the respondents free choice and recall of an encounter with a patient they had seen during the actual week when the interview was performed. The interviews started with an open question; *You have recently seen a new patient*. *Can you tell me about that?* The respondents were free to bring up any subject that came to mind when reviewing the situation, and allowed to continue at length without any interruption. The follow-up questions from the interviewer was based

on a process model of physiotherapy (Tyni-Lenne', 1987), but adjusted and linked to the narrations about the patient. (The interview guide is provided in appendix 1). The reason for this was to propose a possibility for the students to relate to a meaningful context, in which they could speak from their experiences, and not just give answers to abstract and decontextualised questions. This was also concidered as a means to address credibility issues. All the interviews were carried out by the author, in Swedish, tape-recorded and later transcribed verbatim. The transcriptions were then subjected to qualitative analyses.

#### Data analysis

The analysis contains two steps, of which step 1 is a qualitative analysis that results in a pattern of descriptive categories, commensurable to all data. The descriptive categories were generated from the data and not *a priori* defined. In accordance with the phenomenographic perspective, this is considered to be a way of depicting the learning outcome as regards the chosen aspects of study.

Step 2 of the analysis comprises an description of the impact of physiotherapy training and experience in terms of change in conceptions. In several phenomenographic studies, this is conducted by combining the qualitative analysis with quantitative aspects, e.g. the distribution of subjects over the categories on the

different interview occasions is used as a way of describing the impact of education (Alexandersson, 1985; Dahlgren, 1989b) This is also the structure of the present study.

The focus of the analysis of the questions regarding the patient encounter has been on aspects and phenomena transcending the different situations in which the experiences are moulded.

The contextual analysis procedure comprises a cumulative comparison that leads to a description of the internal relations between and within the discerned parts and whole qualities of the phenomenon. After several readings, three aspects common to all narratives were discerned, namely 1) the students' experiences of the communicative process with the patient; 2) the students' descriptions of the patient's problem and the physiotherapeutic treatment, and 3) the students' descriptions of the relationship between themselves and the patient. The meaning of the delimited aspects is searched for in the analysis and furthermore interpreted via the context of each narrative as a whole. The characteristics of the whole narratives are, in turn, constituted by the internal relations between the delimited aspects within the narratives. In the following, I will account for the different phases of the analysis and make an attempt to show how the delimitation of aspects proceeded and how their internal relations were described.

Phase 1. Data reduction The first step in the analysis procedure was to reduce the full account shown in the transcriptions as regards the part of the interview concerning the patient encounter into "core narratives". All follow-up questions and probes from the interviewer were omitted to allow the narrative to appear.

Phase 2. Delimiting of significant aspects within the whole narratives The analysis proceeded by means of thorough and repeated readings of the narratives in order to get a grasp of their meanings as whole entities. The narratives were read with an open question in mind, "what is this all about?".

Phase 3. Description and categorisation of the whole narratives In this phase, the narratives were described in detail and categorised as whole entities. The meaning of the whole of the narrative is interpreted in relation to the conceived context and to how the aspects delimited in phase 2 were conceived of and internally related. This part of the analysis thus combines the analytical and contextual features of contextual analysis.

Phase 4. Description of internal relationships across the pattern of categories The next step in the analysis again focuses on and reveals the internal relationship

between the discerned significant aspects in relation to the characteristics of the categories as wholes, but this time across the pattern of categories obtained. The delimited aspects and their internal relations are utilised in order to compare the categories obtained with regard to similarities and differences.

#### RESULTS: WAYS OF EXPERIENCING THE PATIENT ENCOUNTER

The analysis yielded four main categories that were labelled *A. Mutuality; B. Technicalism; C. Authority;* and *D. Juxtaposition*. In the following, their internal relations are analysed and described in relation to each narrative as a whole.

#### A. Mutuality

These narratives are characterised by the therapists' conscious efforts to establish a relationship with the patient that insures that both parties have agreed on what the problem and the goal of the treatment is. The problem is defined on the disability level, with a focus on functional consequences of the problem. What activities of the patient's daily living are restricted and how could be empowered to take part in the rehabilitation process? Balancing the patient's and the therapist's perspective of the problem is essential and is seen as a prerequisite of a successful compliance with and result of the treatment. Empowerment of the patients' autonomy is important to the therapists within this category. The establishment of mutual goals for treatment, programs for physical training or regimens are imbued with the purpose of making the patient independent.

The mutuality approach is characterised by an emphasis on understanding the patient's experience of illness, emotionally as well as functionally. The subjects expand the interview context to comprise the patient's total life situation. Finding

out what the problem is, in terms of the ways in which the patient's everyday life is affected, is the focus of attention. Put in other words, the subjects' aims are to understand what the problem means to the patient in his life situation.

's'NARRATIVE EXAMPLE: "This patient had gradually become paraplegic due to cancer../My first reflections were 'how am I going to put this'..I tried to find out what her goals were and what expectations she had of the results of our work together.

She really wanted to be able to stand on her feet again, like she had been able to do until just a couple of weeks ago. /.../. From my point of view it looked almost hopeless, but I wanted to oblige her in some way. I suggested that we should try her standing on a tilt table. I wanted her to have the psychological effect of succeeding../../

Since then she improved successively, but now in recent weeks it seems like she is beginning to give up..It is difficult to know what attitude I should show. If I should try to say 'of course you should try to stand' or something like that. Because if she is beginning to give up, I can't force her. It has to build upon her own goals, what she believes in herself. I guess we will have to reconsider that /../ I have tried to put it like she has to be participative,

that she has a responsibility for what she can do..So that she doesn't become dependent on me, that it is only me who can help her". II:PT-12

#### **B.** Technicalism

A central feature of the narratives in this category is that the students try to find the medical explanation of the problem, not by finding out the patient's view of the problem, but by their own interpretation of the information they get from the patient and the findings from the examination. The subjects subordinate the communicative aspects of the patient encounter to the problem-solving aspects that constitute the focus of their attention.

In this category, the patient seems to be objectified and the problem intellectualised by the subjects. The main issue for the students and therapists is to find the cause of the problem, to be able explain the patient's symptoms. The communicative process is characterised by data collection with the patient serving merely as a source of information. The analysis of the patient's life situation in terms of the therapists investigating what functional consequences the problem might have for the patient's everyday life is subordinated to the analysis of the medical problem. These data are supplementary to the medical information and the express purpose of

finding the correct diagnosis as a point of departure for the choice of physiotherapy treatment.

's' NARRATIVE EXAMPLE: "She had a trauma three weeks ago, and severe pain since then. She also had a feeling of tension, and I thought that it might be tendonitis, swollen tendons impinged against the acromion..that might produce a feeling of tension. But due to the trauma I thought that it might also be something with the joint..

The patient told me that since the trauma, she had difficulties in doing push-ups when she was doing work-out with pain and feeling of tension in the shoulder /.../ I examined her and tested../../ testing of the acromio-clavicular joint was positive../../

I wanted to investigate the cause of the problem. That's how I feel... I mean, sure, I can treat the symptoms, and hopefully, the patient will get well.. But the problem might come back and that's not...I think that it is better to find out where the problem comes from..In this case, it was obvious that the trauma caused the problems from the acromio-clavicular joint../.../ The patient doesn't always need a diagnosis from me, that is not my mission, but I try to tell the patient like, 'I have found this and that on you', I try to conclude..'T've found this and what I can do is this'". II:PT-1

#### C. Authority

The prominent features of the narratives in this category are that the control and maintenance of professional authority is essential to the therapists. As in the former category, the problem is defined by the physiotherapist in terms of impairment. The therapist is the active party and the patient the passive. The patient's life context or the functional consequences of the problem are not emphasised. The narratives also contain expressions of the belief in the importance of showing expert knowledge. Contact with the patient is heavily dependent upon the physiotherapist's professional knowledge. This is considered to be the key to getting the patient to confide in the therapist, as well as to motivating the patient to comply with the suggested treatment and it is thus important to give a competent impression. Displaying uncertainty in the therapists' actions or knowledge should be avoided.

's' NARRATIVE EXAMPLE: "This is a woman/../ who has a pain in her neck and shoulders, radiating to her left arm../../ I let her tell me at her own pace and then I asked the questions I wanted, I mean purely physiotherapeutic..In this first meeting, I think it is important to be clear.. I think that it is difficult to know what to do for the patient, we've learned all these examination techniques and what to expect, but then the findings

almost fall on the fact that you don't know so much about different treatments..you start to think, well, what can I actually do..

When I left her, I felt that I didn't really know what to do, I had to sit down and think over some suggestions for her, and the next time she came back I had come to the conclusion that it would be good for her to train actively in the gym. I didn't exclude anything..I think according to this tree, you know; muscular problems or nerves or specific joint problems..I did a neurological status, but I found that diffuse. I think that I probably think a little to much about what to do, but not always why..it is often like; I'll try this and this and this, so I don't always get a grasp of the examination as a whole../../..

I think it's important that you follow a certain order when you do the tests you've learned..I think you have to... at least I want to be sure of what findings to expect from the different tests".(II:5-3)

#### **D.** Juxtaposition

In this category, the communicative process is juxtaposed with the problem-solving process. Typically, the narratives describe a paradox between the subjects' intention of taking the patients' perspective of the problem and still maintaining the perspective of the physiotherapist. The narratives in this category contain several linguistic expressions of the importance of the communicative aspects of the

encounter with the patient. Listening to what the patient experiences as the main problem is perceived as a main point of departure for both the physiotherapeutic examination and treatment. Despite this, the definition of the problem is made from the physiotherapist's point of view. The subjects seem to concentrate on listening to the patient, but cannot integrate the information with the problem solving.

's' NARRATIVE EXAMPLE: "He told me that he had been to several therapists who had tried to do something about his problems..he had a lot of treatment series, and nothing had helped him, he said./.../ I think it's difficult with this kind of patient, I have only read about how to do it.. The patient should be allowed to speak freely all the time, and you should hardly pose any questions at all, just repeat the last sentence or so of what he tells you, so that he keeps on talking.. It doesn't always work..It worked from the beginning, but then I started to ask questions that maybe interrupted what he was talking about.. Maybe I jumped into something completely different, just because I was interested in getting to that../it is difficult to know what to start with, and what it is that should come out of it.../../ I examined him according to this examination sheet../../ and marked the range of motion, tension in the muscles and things like that.. I found that he had difficulties in relaxing /../and that he was a bit tense /../ I still think it's difficult to feel what is tense and not tense, I have too little experience/../ but with him, it was

quite clear, when you palpated the muscles, you felt that they were tense" I:5-13

The pattern of categories and their internal relationships

The analytical and contextual parts of the contextual analysis are placed together and illustrated by a graph to depict the relationships between the categories (Figure 1). Changes between the two interview occasions in both groups are shown in Table 1 and 2.

The horisontal rows of all tables show and summarise the distribution of subjects over the categories at the first interview. The columns of all tables show and summarise the distribution at the second interview. In this way, all tables display the directions of change in conceptions over the category system between the interviews.

The distinctive resemblances and differences between the categories concerned the internal relationship of two aspects of the patient encounter; the communicative and problem-solving processes and the physiotherapist-patient relationship. The internal relationship of the communicative and the problem-solving processes

involved was described in two qualitatively different ways, as integration or separation of processes.

Integration of the processes meant that the descriptions of the examination process were intertwined with the information gathered from the patient. The problem-solving process was guided in a natural and logical way by the communication with the patient. The categories *Mutuality* and *Technicalism* both denote an integration of the communicative and problem-solving processes, the former category from a patient-centred and the latter from a physiotherapist-centred perspective.

Separation of the processes meant that the narratives expressed an emphasis on either communicative aspects or the problem-solving process. This was also described as a figure-ground relationship. Either the communicative or problem-solving aspects were conceived as figure while the other aspect was conceived as ground. The categories *Authority* and *Juxtaposition* both denoted a separation of the processes, the former category from a physiotherapist centred perspective and the latter from a patient-centred perspective.

Changes as regards ways of experiencing the communicative and problem-solving processes

The outcome as regards change during the formal education showed that the separated perspective dominated during the second term of the physiotherapy

education programme (Table 3). A majority of the subjects were found in the juxtaposition and the authority categories. About one third of the subjects maintain the perspectives held at the time of the first interview, while another third have changed from a separated to an integrated perspective, comprising the mutuality and the technicalism categories. A few subjects change from an integrated to a separated perspective.

The results from group II (Table 4) showed a more distinctive change from the separated to the integrated perspectives after 18 months of professional practice. At the first interview at the end of the educational programme, the results showed an approximately even distribution of subjects over the category system. The results of the second interview showed that a majority of the subjects had changed to an integrated perspective of the communicative and problem-solving processes. At the second interview the mutuality category dominated in quantitative terms.

The perspectives of the physiotherapist-patient relationship were labelled patient-centred and physiotherapist-centred, respectively. The patient-centred view was characterised by an emphasis on equality and adaptation in the relationship between the physiotherapist and the patient. The physiotherapist-centred view was characterised an emphasis on the physiotherapist's actions.

Changes as regards perspectives of the physiotherapist -patient relationship

The dominating approach in group I at the beginning of the educational programme was a patient-centred perspective (Table 5). A majority of subjects changed, however, to a physiotherapist-centred perspective at the end of the programme. The outcome in group I at the second interview was similar to the result of the first interview in group II, where the physiotherapist-centred perspective dominated. At the second interview after 18 months of professional practice, the dominating perspective had shifted. A majority of the subjects were then found to have a patient-centred perspective of the physiotherapist-patient relationship (Table 6).

#### **DISCUSSION**

The nature of the change in conceptions should be understood as a change in the subjects' ability to discern and be simultaneously and focally aware of other or more aspects of the phenomenon than prior the learning experience (Marton & Booth, 1997), rather than as a shift from one conception to another in a more definite sense. Increasing integration of different aspects of phenomena and their meaning, as well as knowledge about the relationships between the different aspects, is also the kind of impact of higher education shown by, for instance, Perry (1970) or Hasselgren (1981).

A plausible explanation of the direction of change as regards the student - patient relationship could be the fact that communication skills are emphasised from the start of the programme. The students learn that a patient-centred perspective is important before they have acquired the skills needed to reach this in the patient encounter. As the programme proceeds, learning technical physiotherapeutic skills become more important and the students have to focus on this to be able to manage the situation with the patient, and the interaction with the patient on equal terms becomes marginal. A physiotherapist-centred perspective, as in the authority and technicalism categories, thus helps the students to maintain control. This perspective resembles a traditional paternalistic conception of a therapist as an authoritative expert and the patient as a passive party in the encounter (Roter & Hall, 1992). This perspective is also most common in the first interview in group II.

The large extent of change to a patient-centred conception within the mutuality category after 18 months' experience of clinical physiotherapy practice might show that the students do not manage to achieve a patient-centred attitude during the course of the educational programme, but they are prepared for this relatively soon afterwards during the subsequent clinical practice as physiotherapists. In this respect, my results differ compared to the previous novice-expert studies of the development of expertise in physiotherapy and other caring professions where this

dimension seems to be established later in the professional career and is characterised as a feature of professional expertise (Martin *et al*, 1993).

In the Swedish Health and Medical Services Act it is emphasised that health and medical care should be provided from a multifaceted and patient-oriented perspective. It is also stipulated that health care should be based on respect for the patient's autonomy and integrity. Moreover, health care efforts should be offered and implemented in co-operation with the patient. The overarching educational objectives are as a result also imbued with this perspective.

My results comprise ways of experiencing the patient encounter where the physiotherapists take control of and dominate the situation. This is accomplished at the expense of the patients' participation in decision-making throughout the physiotherapy process. Similar results have also been obtained in previous studies (Ek, 1990; Engelsrud,1990; Thornquist, 1994 a,b; Westman-Kumlien & Kroksmark, 1992; Abrandt, 1995). This could mean that these physiotherapists have adopted a paternalistic view of their relationship to the patient.

An alternative explanation could be that the professional reality includes confrontations between perspectives held by other professional groups on the caring team which differ from or are even contradict the professional discourse of

physiotherapy as expressed in the educational objectives. Bergman (1989) showed that many physiotherapists have difficulties in claiming their specific professional autonomy and thus become subservient to organisational demands rather than being able to organise and carry out their work in a way that is believed to be more beneficial for their patients and clients. Abrandt (1995) suggested that physiotherapists adjusted to the medical discourse and allied themselves with the physicians in order to increase autonomy in their professional work, and that a biomedical and organ-oriented perspective sometimes dominated the relationship to the patient.

On the other hand, confrontation between different perspectives could also occur if the patient's expectations are different to the physiotherapist's. Even if the physiotherapist's own preference would be a relationship on equal terms with the patient, based on a holistic perspective of health and disease, the patient might be carrier of a biomedical perspective and expect the physiotherapist to play an authoritative role in the encounter which would force the physiotherapist into such a professional role. The *mutuality* conception of the patient encounter includes other roles for the patient than that of participating, thus mirroring the patient's expectations and desires to meet a physiotherapist who takes full responsibility for all decisions. The most flexible conception of the patient encounter is thus - paradoxically - also giving way to the more traditional perspectives of the role of

the physiotherapist. To guarantee the patients' influence in health care, however, the demand for a mutuality perspective as an educational objective in physiotherapy curricula appears to be imperative.

#### **CONCLUSION**

To summarise, the general trends in the results are

- change from separated to integrated perspectives on the communicative and problem-solving processes in both groups;
- change from a patient-centred to a physiotherapist-centred conception of the therapist-patient relationship after the educational programme; and
- change from a physiotherapist-centred to a patient-centred conception after 18 months of professional experience.

The results of the qualitative analyses in this study could contribute to the understanding and assessment of clinical competence within physiotherapy education. The categories *Mutuality*, *Technicalism*, *Authority* and *Juxtaposition* portray different ways of thinking in physiotherapy that could be utilised as stimuli for reflection as well as assessment criteria in clinical education. They offer a way of making the students aware of various ways of thinking, and thereby a possibility to enhance reflective practice.

**Table 1.** Group I: Ways of experiencing the patient encounter. Distribution of subjects over the categories on the two interview occasions

Term 5

							_
		A. Mutuality	B. Technicalism	C. Authority	D. Juxtaposition	Drop- outs	Total
	A.						
	Mutuality	1	0	2	0	0	3
	B.						
Term 2	Technicalism	0	0	0	0	0	0
	C.						
	Authority	2	0	2	0	3	7
	D.						
	Juxtaposition	1	2	3	1	0	7
	Total	4	2	7	1	3	17

**Table 2.** Group II: Ways of experiencing the patient encounter. Distribution of subjects over the categories on the two interview occasions

18 months	of professional	work
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		A. Mutuality	B. Technicalism	C. Authority	D. Juxtaposition	Drop- outs	Total
	A.						
	Mutuality	2	0	0	0	0	2
Term 5	B.						
	Technicalism	4	2	0	0	0	6
	C.						
	Authority	2	0	2	0	0	4
	D.						
	Juxtaposition	2	0	2	0	1	5
	Total	10	3	3	0	1	17

**Table 3.** Group I: Distribution of subjects over the categories as regards the relationship between the communicative and problem-solving processes on the two interview occasions

		Term 5				
		A+B Integrated	C+D Separated	Drop-outs	Total	
T. 2	A+B Integrated	1	2	0	3	
Term 2	C+D Separated	5	6	3	14	
	Total:	6	8	3	17	

**Table 4.** Group II: Distribution of subjects over the categories as regards the relationship between the communicative and problem-solving processes on the two interview occasions

#### 18 months of professional work

		A+B Integrated	C+D Separated	Drop-outs	Total
T. 2	A+B Integrated	8	0	1	9
Term 2	C+D Separated	4	4	0	8
	Total:	12	4	1	17

**Table 5.** Group I: Distribution of subjects over the categories on the two interview occasions as regards the student-patient relationship

		A+D Patient-centred	B+C Physiotherapist -centred	Drop-outs	Total
Tarma 2	A+D Patient-centred	3	7	0	10
Term 2	B+C Physiotherapist -centred	2	2	3	7
	Total	5	9	3	17

**Table 6.** Group II: Distribution of subjects over the categories on the two interview occasions as regards the student-patient relationship

18 months of professional work

		A+D Patient-centred	B+C Physiotherapist -centred	Drop-outs	Total
Term 5	A+D Patient-centred	4	2	1	7
1erm 3	B+C Physiotherapist -centred	6	4	0	10
	Total	10	6	1	17

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#### **REFERENCES:**

Abrandt, M. Ängslyckans sjukgymnastik. [Meadoway Physiotherapy]. Sjukgymnasten, Vetenskapligt Supplement 1995; 4-13.

Albanese, M. A., & Mitchell, S. Problem-based learning: A review of literature on its outcome and implementation issues. Academic Medicine, 1993; 68: 52-81.

Alexandersson, C. Stabilitet och förändring. [Stability and change]. Göteborg: Studies in Educational Sciences. 53, 1985.

Bergman, B. Being a physiotherapist -professional role, utilization of time and vocational strategies. Umeå: Umeå University Medical Dissertations, 1989.

Boud, D., & Feletti, G. (Ed.). The challenge of problem-based learning. London: Kogan Page, 1991.

Dahlgren, L. O. Fragments of an economic habitus. Conceptions of economic phenomena in freshmen and seniors. *European Journal of Psychology of Education,IV* 1989b;4: 547-558.

Dahlgren, L. O., & Fallsberg, M. Phenomenography as a qualitative approach in social pharmacy research. Journal of Social and Administrative Pharmacy 1991;8:150-156.

Deber, R.B. Physicians in health care management: 8. The patient-physician partnership: decision making, problem solving and the desire to participate. Canadian Medical Association Journal 1994; 4: 423-427.

Ek, K. Physical therapy as communication: micro analysis of treatment situations. Dissertation Michigan University, USA, 1990.

Engelsrud, G. Kroppen - glemt eller anerkjent. [The body - forgotten or recognised]. In K. Jensen (Eds.), *Moderne omsorgsbilder* Gyldendal: 1990;160-180.

Hasselgren, B. Ways of apprehending children at play: a study of pre-school teachers' development. Göteborg: Studies in Educational Sciences. 38, 1981.

Kjellgren, K., Ahlner, J., Dahlgren, L. O., & Haglund, L. (Eds.). Problembaserad inlärning - erfarenheter från Hälsouniversitetet. [Problem based learning - experiences from the Faculty of Health Sciences]. Lund: Studentlitteratur, 1993.

Martin, C., Thornberg, K., & Shepard, K. The professional development of expert clinicians in orthopedic and neurological practice. Sjukgymnasten, Vetenskapligt Supplement, 1993; 12-21.

Marton, F. Phenomenography - describing conceptions of the world around us. Instructional Science, 1981;10:177-200.

Marton, F., & Booth, S. Learning and awareness. Mahwah, N.J.: Erlbaum Associates, 1997.

Marton, F., Dahlgren, L.-O., & Säljö, R. Inlärning och omvärldsuppfattning. [Learning and conceptions of reality]. Stockholm: Almqvist &Wiksell, 1977.

Perry, W. Forms of intellectual and ethical development in the college years: A scheme. New York: Holt, Rinehart & Winston, 1970.

Roter, D.L.& Hall, J.A. Doctors talking with patients - patients talking with doctors: Improving Communication in Medical Visits. Westport, Conn.: Auburn House, 1992.

Strull, W.N., Lo, B., & Charles, G. Do patients want to participate in medical decision making? Journal of American Medical Association, 1984;11:367-374.

Svensson, L. Study skill and learning. Göteborg: Studies in Educational Sciences. 19, 1976.

Svensson, L. Contextual analysis - The development of a research approach. In 2nd Conference on Qualitatve Research in Psychology., Leuden, The Netherlands, 1985

Svensson, L. Fenomenografi och kontextuell analys. [Phenomenography and contextual analysis]. In R. Säljö (Eds.), Som vi uppfattar det Lund: Studentlitteratur, 1989;33-52.

Swedish Code of Statutes. SFS, 1982:763; SFS, 1985:560

Säljö, R. Qualitative differences in learning as a function of the learner's conception of the task. Göteborg: Studies in Educational Sciences. 14, 1975.

Thornquist, E. Profession and life: Separate worlds. Social Science & Medicine, . 1994a; 39:701-713.

Thornquist, E. Varieties of functional assessment in physiotherapy. Scandinavian Journal of Primary Health Care, 1994b; 12: 44-50.

Tyni-Lenné, R. Fysioterapins kunskapsområde. [The physiotherapeutic field of knowledge]. In Broberg, C., Westman-Kumlien,I., Schön-Olsson,C. & Wallén, G. (Eds.), Vetenskaplig utveckling av sjukgymnastik Internordiskt symposium, FoU rapport 1, 1987; 83-96.

Westman-Kumlien, I. & Kroksmark, T. The first encounter: Physiotherapists' conceptions of establishing therapeutic relationships. Scandinavian Journal of Caring Sciences, 1992; 6: 37-44.