To look and behave like a professional: the practical accomplishment of hospital-located physiotherapy education.

Clare Margaret Kell

Presented for the degree of Professional Doctorate in Education

School of Social Sciences
Cardiff University

December 2012
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>iv</td>
</tr>
<tr>
<td>University Declarations</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
<tr>
<td><strong>Chapter 1: Placing the thesis in context</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Journeying towards a Professional Doctorate</td>
<td>1</td>
</tr>
<tr>
<td>1.3 False starts and lessons in noticing</td>
<td>2</td>
</tr>
<tr>
<td>1.4 Orientating the reader to the thesis</td>
<td>4</td>
</tr>
<tr>
<td><strong>Chapter 2: Reviewing the literature: a journey in learning about learning</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>6</td>
</tr>
<tr>
<td>2.2 The UK profession of physiotherapy, its pre-registration education and relevance to this study</td>
<td>6</td>
</tr>
<tr>
<td>2.3 Troubles arising from an early focus on the pedagogic discourse of Physiotherapy placement education – and some progress</td>
<td>10</td>
</tr>
<tr>
<td>2.4 Observations and reflections from reading non-physiotherapy-focused workplace learning research</td>
<td>18</td>
</tr>
<tr>
<td>2.5 From literature review to practice: arriving at a focus for my project</td>
<td>30</td>
</tr>
<tr>
<td><strong>Chapter 3: Methodology</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>33</td>
</tr>
<tr>
<td>3.2 Preliminary concerns: challenges of being a good witness</td>
<td>33</td>
</tr>
<tr>
<td>3.3 The methodological approach to my study: does it have a label?</td>
<td>36</td>
</tr>
<tr>
<td>3.4 Preparations for my fieldwork</td>
<td>42</td>
</tr>
<tr>
<td>3.5 Practices in the field</td>
<td>49</td>
</tr>
<tr>
<td>3.6 Doing the data justice and not arguing with the members</td>
<td>52</td>
</tr>
<tr>
<td>3.7 Chapter conclusion</td>
<td>54</td>
</tr>
<tr>
<td><strong>Chapter 4: Experiencing a neuro placement</strong></td>
<td></td>
</tr>
<tr>
<td>4.1 Introduction</td>
<td>55</td>
</tr>
<tr>
<td>4.2 Setting the scene</td>
<td>55</td>
</tr>
<tr>
<td>4.3 The mechanics of the placement</td>
<td>56</td>
</tr>
</tbody>
</table>
### Chapter 4: Experiencing a neuro placement

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4 The aims and focus of the placement</td>
<td>57</td>
</tr>
<tr>
<td>4.5 Experiencing a neuro placement</td>
<td>59</td>
</tr>
<tr>
<td>4.6 Typical learning opportunities on this neuro placement</td>
<td>60</td>
</tr>
<tr>
<td>4.7 Selecting the field extracts to present in this chapter</td>
<td>62</td>
</tr>
<tr>
<td>4.8 The practical accomplishment of neuro physiotherapy education</td>
<td>63</td>
</tr>
<tr>
<td>i) Preparing to see a patient</td>
<td>63</td>
</tr>
<tr>
<td>ii) Patient-focussed placement interactions</td>
<td>66</td>
</tr>
<tr>
<td>a. Settling into the interaction</td>
<td>67</td>
</tr>
<tr>
<td>b. Conducting the physical assessment</td>
<td>71</td>
</tr>
<tr>
<td>c. Session closure and extraction from the interaction</td>
<td>78</td>
</tr>
<tr>
<td>d. Creating physiotherapy work through dialogue and note writing</td>
<td>80</td>
</tr>
<tr>
<td>4.9 Chapter summary</td>
<td>91</td>
</tr>
</tbody>
</table>

### Chapter 5: Experiencing a musculoskeletal placement

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Introduction</td>
<td>93</td>
</tr>
<tr>
<td>5.2 The context and planning of a musculoskeletal placement</td>
<td>94</td>
</tr>
<tr>
<td>5.3 Students' ‘core’ work patient-facing interactions</td>
<td>98</td>
</tr>
<tr>
<td>i) The context of students’ typical core MSk placement experiences</td>
<td>98</td>
</tr>
<tr>
<td>ii) Preparing to see a new MSk patient</td>
<td>100</td>
</tr>
<tr>
<td>iii) The early phases of an MSk new patient assessment</td>
<td>102</td>
</tr>
<tr>
<td>iv) The subjective assessment</td>
<td>106</td>
</tr>
<tr>
<td>v) The post-subjective assessment debrief</td>
<td>114</td>
</tr>
<tr>
<td>vi) The objective assessment</td>
<td>120</td>
</tr>
<tr>
<td>vii) The post-objective assessment debrief</td>
<td>132</td>
</tr>
<tr>
<td>viii) Closing the patient interaction</td>
<td>135</td>
</tr>
<tr>
<td>ix) Writing up and signing off the patient’s treatment record</td>
<td>138</td>
</tr>
<tr>
<td>5.4 Reflections from the observation of students at work in ‘core’ MSk  patient interactions</td>
<td>141</td>
</tr>
<tr>
<td>5.5 A Brief aside: observations of MSk students’ learning in other settings</td>
<td>142</td>
</tr>
<tr>
<td>5.6 Chapter summary</td>
<td>143</td>
</tr>
</tbody>
</table>
Chapter 6: Doing placement education: comparing interaction practices across settings

6.1 Introduction
6.2 The process of data analysis and synthesis
6.3 The 'hows' of the neurology placement
   i) The practice of Intercorporeal Knowing
   ii) The verbal practices of placement educators
   iii) Interaction practices between group members
6.4 The 'hows' of the Musculoskeletal placement
   i) The Placement Educator-led student debriefs
   ii) MSk student: student interaction practices
   iii) Further discussion about student: patient interactions
6.5 Chapter summary: synthesising some 'whats' from the 'hows'
6.6 Conclusions

Chapter 7: Concluding remarks

7.1 A journey in noticing and creating noticing-sensitive data collection tools
7.2 The status of the data and its analysis
7.3 Placement education: from policy to practice
7.4 Implications of this study for the placement education of physiotherapy students
7.5 Reflections on this project and recommendations for further study

Reference list
Appendices

1. Full text of ward-based neuro placement interaction sequence.
2. Getting into the neuro placement mind-set: preparing for a close exploration of students’ learning experiences.
3. Learning in neuro by co-working with qualified colleagues.
4. Making sense of MSk Placements: exploring the access interviews.
5. The Hydrotherapy experience.
6. Techniques practice: teaching professional vision and knowing in practice.
Summary

This thesis provides a window into the world of work-placement-based pre-registration physiotherapy education in the UK. This empirical study followed final year students as they went about their everyday practices on placement in hospital-based settings. Adopting a perspective sensitive to social theories of learning, and drawing on ideas and methods from ethnography and interactional sociologies, the project makes visible some of the complex, but taken-for-granted, interactional practices and processes by which students, their educators and patients co-enact their work of physiotherapy student education.

How placement education is actually done - its practical accomplishment - is captured by focusing on the minutiae of participants’ interaction performances. Physiotherapy practice interactions typically involve participants’ use of space, speech, paralanguage, touch and movement of themselves and others. The research required the development of a new method for recording interaction proxemics, kinesics and verbal elements in real time and with only paper and pencil. Created from the ideas of choreographers, social anthropologists and video/conversational analysts, the multi-modal data sets generated by the method bring interactions to life and enable the detailed exploration of participants’ practices.

The evidence collected suggests that placement learning experiences are an integral part of professional development framed within a situated learning environment where the dominant discourse is of ‘physiotherapy as science’. The evidence also suggests that students’ placement practices adapt to satisfy the needs of their summative assessment. The thesis considers the impact of placement education interactions on the patients about whom they orientate.

The thesis, and the new method it describes, is immediately relevant to the practice of physiotherapy, its education programmes and professional project discussions. The quality of the interaction data presented in this thesis makes physiotherapy practice education accessible and available for others to explore, and the method is suitable for transfer to other studies of human interaction.
University Declarations

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

Signed …………………………………………………………. (candidate)

Date …………………………………………………………. (candidate)

STATEMENT 1

This thesis is being submitted in partial fulfillment of the requirements for the degree of PhD.

Signed …………………………………………………………. (candidate)

Date …………………………………………………………. (candidate)

STATEMENT 2

This thesis is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references.

Signed …………………………………………………………. (candidate)

Date …………………………………………………………. (candidate)

STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed …………………………………………………………. (candidate)

Date …………………………………………………………. (candidate)
Acknowledgements

My first and greatest acknowledgment must be to the students, physiotherapists and patients who let me into their world to observe the intimacy of their workplace interactions. Without the openness of their welcome and their tolerance of my intrusion there would have been no project. I also acknowledge the support and practical advice I received from the plethora of gatekeepers who protect the sanctity of patient-facing therapy. I thank them for having faith in my project and trust in my ability to deliver it.

I am fortunate to have had the opportunity to embark on a programme of study that has had life-changing impact. I shared the first part of the journey with my fellow EdD travellers and I thank them for showing me what I had missed about working inter-professionally. Their accounts and reflections started the process of questioning my underpinning professional lens and the origins of those assumptions which led me ultimately to this thesis.

Central to the development of this project, and myself as a social scientist, has been the enthusiastic and unwavering support of my supervisors Professor Tom Horlick-Jones and Dr Jane Salisbury. I thank Tom specifically for his ability to find just the resource I needed to open up new ideas and pathways, for his patient challenges to my early certainties and his unstinting belief in the project. I thank Jane for her invaluable insights and observations about my stick people’s ability to bring alive the minutiae of the healthcare interactions I observed.

I am fortunate to have colleagues, old and new, who, over many years, have proved rigorous critics and sounding boards, and provided much valued optimism, encouragement and most recently space to think and write. I am also grateful to fellow conference attendees for their validation and challenge to my evolving ideas and method.

Finally, but by no means least, I am especially grateful to Jonathan, Anna, Emily and Ruth for their love, support (and invaluable Mac computer skills), blindness to grumpiness and tolerance of my withdrawal from family life. Thank you for your belief in me and that the price was worth paying.
Chapter 1: Placing the thesis in context.

1.1 Introduction

This thesis completes my study for a Professional Doctorate in Education. I chose to undertake the Professional Doctorate programme in a School of Social Sciences as I wanted to look at my profession, physiotherapy, from a different perspective (as will become clear later in this chapter I did not know what sort of perspective – but I sensed there was more to the world than my physiotherapy training had explored). The intention has always been to offer my learning from the programme and related study to the profession for discussion. This thesis is a significant outcome from my studies but only begins the process of dissemination to my professional community. While located firmly within the world of physiotherapy, the text is also the story of my journey in social science ideas and perspectives and as such I use the first person to write both reflectively and reflexively throughout. In this first chapter I set the scene for the empirical study underpinning this thesis, and orientate readers to the thesis’ intentions and structure.

1.2 Journeying towards a Professional Doctorate

I qualified as a Physiotherapist in the UK in 1988. Physiotherapy is a protected title healthcare profession with a focus on human movement and function. The reference to my being a UK therapist is deliberate and orientates readers to my membership of a form of the world-wide profession that defines itself as ‘science-based’ (CSP 2002, p.19). Post-registration I practised clinically in a pattern typical of many new therapists. For the first eighteen months I worked for four months at a time in a range of attachments or placements to hospitals and wards within hospitals. This period, known as the ‘junior rotations’, sends newly qualified staff to a range of therapeutic specialities (labelled by the medically diagnosed conditions of the patients populating those ward e.g. ‘medical’, surgical’ etc.) to deepen the integration of theory with practice that began during their pre-registration education¹. A series of applications and promotions saw me move first to the next level of, slightly longer (6 month), rotations, and then to a ‘specialist’ rotation for neurological therapy.

¹ In its December 2011 submission to the UK Health Select Committee Enquiry into Education, Training and Workforce Planning, the CSP argued that the principle of ‘broad based rotations’ be retained in any NHS Workforce re-shaping as they ‘are needed to ensure that the newly qualified are able to develop their skills in a variety of clinical settings, including to support their subsequent progression to advanced and specialist roles. This ensures that the physiotherapy workforce will have the necessary transferrable skills and flexibility needed to be able to adapt to changes in health care provision rather than specialising too early in their careers’ CSP (2011) CSP submission to the Inquiry into Education, Training and Workforce Planning. Health Select Committee.
as I honed my possible career direction. Taking students as a Placement Educator sparked an interest in education that led me through other clinical posts to the role of ‘Student Teacher’ in a university-based physiotherapy education team.

UK pre-registration programmes have university- and work-placement based components with all students required, by the national accrediting body (the Health and Care Professions Council; HCPC), to complete approximately 1000 hours of learning in practice-based settings. Placement education is usually provided by practising physiotherapists who take on the education role in addition to their therapeutic caseload.

As a junior academic I sought to understand how curricula impact on students’ learning. Through a series of longitudinal quantitative studies I explored the possible impact of the university-based elements of a pre-registration curriculum on the change overtime of certain dimensions of students’ learning profiles that were considered to be related to their development of the learning characteristics and personal belief systems of lifelong learners. Over the course of ten years my colleagues and I made interesting observations and curricular adjustments (for example Kell 2006) but recognised the need to explore students’ learning in placement settings.

Perhaps surprisingly given the significant time allocated to placement learning within pre-registration programmes, little research has been undertaken in the UK into real time placement education practice. My colleagues and I undertook several small-scale projects to begin mapping the complexity of the placement learning environment (Kell and Jones 2007; Kell and Owen 2009), but we knew we needed to experience naturally occurring placement education. The depth and scale of study required at doctoral level provided the context to legitimate the use of sufficient resources to conduct empirical fieldwork. The primary intention of my thesis project was therefore to build on my earlier work and explore students’ learning experience in work-placement settings.

1.3 False starts and lessons in noticing

When I started my doctoral studies I no longer practised as a physiotherapist, but my training, clinical work specialising in neurological rehabilitation and later roles as a university-teacher had collectively, over twenty years, influenced profoundly what I valued and noticed about the world around me. While I taught that UK physiotherapy was a science-based profession, I had given no thought to whether or how a perspective of science influenced my daily preparation of lessons, interaction with students and my placing of patients in
physiotherapeutic settings. Indeed, I was so blind to my own assumption-making that colleagues recount a conversation I had when preparing to begin my EdD studies in which I assured concerned acquaintances that ‘there can’t be much difference between science and social science’!

As one might expect from this starting point, the journey through the taught phase of the doctoral programme was transformative and deeply challenging. Through the course of this thesis I will describe how my learning during these two years opened up possibilities for the thesis but could do little to prepare me for the jolt to my life view that took place when I started trying to put theory into research practice. My journey as a fledging social scientist and the progress of my empirical study are so closely intertwined that this thesis explores both the study and charts and celebrates my personal development.

Maxwell Atkinson’s (1978) book arising from his PhD study Discovering Suicide has been particularly influential in helping me develop a writing style for this thesis. Atkinson embarked on a study that he thought would be quantitative in nature and data driven. Early in his project he explored the way that suicide cases were categorised in the data sets he was using and questioned the assumptions leading to this categorisation. Cycles of ‘reading, researching and writing’ saw his thesis project ‘shift from positivism to interactionism to ethnomethodology’ (p. 6). Rather than cleaning his thesis of its twists, turns, false starts and misplaced assumptions, Atkinson wrote his text as a journey in an attempt ‘to preserve the logic of the research as (he) understood it at different stages of its development’ (p. 6). Following Atkinson on his journey is a fascinating read and enabled me to recognise how my background, the challenges of my preconceptions and the pull-up moments that littered the progress of this project, influenced what I did and did not notice about the research environment at different stages of the research process.

In this thesis therefore, my research journey and personal development are made visible through the narrative form and ‘voice’ with which each chapter is written. The change in my noticing and critical engagement with my data is particularly evident between the two results chapters (Chapters 4 and 5). Each results chapter discusses the fieldwork data collected in each of the two placement education sites observed in this study. The wealth of data generated by the fieldwork led me to explore and write about each placement site separately. Chapter 4 was thus written in its entirety before I began analysing the fieldwork evidence from the second site. Chapter 4 is descriptive in nature and may at times seem naïve. However, following Atkinson’s (1978) example, I have resisted the temptation to go back and re-write Chapter 4 in light of my thinking by the end of Chapter 5 because such an
edit would obscure the development of my noticing, which was itself a critical step in the research process. I hope readers will tolerate and enjoy this additional dimension.

1.4 Orientating the reader to the thesis

With the background context for the project and the underpinning framework for writing this thesis briefly introduced, I conclude this chapter by orientating readers to the structure of the remaining text.

Chapter 2 locates the project in the context of my own experiences and a critical discussion of the literature in the areas of learning generally and learning in workplace contexts specifically. The chapter draws on a wide range of health and non-health related education literatures to discuss how I learned to embrace ideas and methods from ethnography and interactional sociologies, in particular ethnomethodology. Chapter 2 thus illustrates the origins of the perspectives I adopted to undertake the current study and the research questions that framed it.

In Chapter 3 I discuss the methodology and approach I adopted to explore how placement education is done, and the practical preparations for my time in the field observing pre-registration placement education in two hospital settings. Chapter 3 introduces the new method I developed for collecting real time fieldwork evidence of how participants in placement interactions use verbal and non-verbal interaction practices to co-produce the interaction as physiotherapy education.

Chapters 4 and 5 describe the data collected in the two placement sites: neurology and musculoskeletal respectively. Given the wealth of data I collected and its value in understanding the complexity of students’ placement learning experiences, these chapters deliberately discuss only part of each dataset and illustrate how the data processing and preliminary analyses were conducted. Explorations of more context-specific placement learning practices have been created as case studies in the Appendix.

The full datasets (Chapters 4 and 5 and their related Appendices) ground the intra- and inter-context analyses and syntheses in Chapter 6. Chapter 6 thus uses the mundane everyday placement learning activities described in Chapters 4 and 5 to explore how placement education in each site is accomplished, and to suggest the work that those practices may be performing for physiotherapy as a profession. Chapter 7 draws the
discussions back to focus on the relevance of the project findings to the practice and further study of physiotherapy placement education in the UK.

Collectively Chapters 2 to 7 illustrate my deepening critical engagement with a broad seam of sociological ideas and an ability to demonstrate their relevance to, and analytical purchase on, the practical activities of specific social groups in specific workplace settings. The thesis evidences two main claims of social research originality: the real time ethnomethodologically-informed ethnographic observation of UK physiotherapy students 'in the field', and the development of a pencil and paper data collection method that created the multi-faceted datasets upon which the thesis is based. In this thesis, through the collection of naturally-occurring data and thus by listening to the members' voices (Pollner 2012), I have attempted to bring the world of physiotherapy placement education alive so that you feel you have been with me on this journey.
Chapter 2: Reviewing the literature: a journey in learning about learning.

2.1 Introduction

This chapter lays the foundations for the study reported in this thesis and places it in the context of a range of perspectives and foci within which related studies by others have been undertaken. The challenge in writing the chapter has been to demonstrate my engagement with a breadth of ideas and debates about workplace learning research while being true to the major learning journey I have experienced through the readings and critical reflections such debates provoked. Cognisant of the word limit constraints, and keen that the emphasis of this thesis is placed on the results of my project and their discussion, I have selected for inclusion here only the key ideas that acted as learning moments in the development of this study. This chapter thus charts out the field of ideas and related studies but with little critical appraisal. As the thesis progresses however, and especially in Chapters 6 and 7, I interweave a discussion of the study’s findings with a more robust critique of the literature introduced here.

The chapter is written in four sections. Firstly, and briefly, I introduce readers to the profession of physiotherapy in the UK, locate the current study in a discussion about the pre-registration education of physiotherapists and describe the original project intentions. These discussions lead to the second section of the chapter that both introduces the troubles that arose from pre-fieldwork activities and explores some solutions. The third section foregrounds the final project and locates it in a critique of research in non-physiotherapy work-placement education study contexts. The chapter concludes with an articulation of the focus and proposed extent of my doctoral study and its claim to originality.

2.2 The UK profession of physiotherapy and its pre-registration education

i) A synopsis of UK physiotherapy’s professional project

Physiotherapy (or Physical Therapy outside the UK) is a healthcare profession whose members provide ‘services to individuals and populations to develop, maintain and restore maximum movement and functional ability through the lifespan’ (World Confederation of Physical Therapy 2011, p. 2). A ‘deep and broad understanding of normal movement and impaired function’ founded on both ‘empirical and clinical evidence’ is claimed as the profession’s ‘unique’ knowledge base (Higgs et al. 2001, p. 82). The 106 countries worldwide who are members of the WCPT, and the c350 000 therapists whom they
represent, frame their practice within the WCPT guidance but tailored to the specific requirements and expectations of their local healthcare systems and country-specific professional bodies.

Physiotherapy in the UK can be traced back to 1894 when four London-based midwives and nurses formed the Society of Trained Masseuses (STM) to protect their practice of therapeutic massage from ‘scandals of massage’ slurs spread within the British Medical Journal of that year (BMJ 1894). The consequences of the women’s decision to form an association to teach massage and provide ‘certificates of proficiency’ in ways that explicitly aligned with the discourses of the late nineteenth century British medical profession have been rehearsed elsewhere (Barclay 1994; Dixon 2005; Kell and Owen 2008). Here it is notable that, from its very beginnings, in order to ‘make massage … an honourable profession for British women’, the founding Society members adopted Medicine’s biomechanical approach to health and illness (Nicholls and Cheek 2006, p. 2342). After its establishment, the Society ran short courses, overseen by Medical Board members, teaching visual- and touch-based assessment skills and therapeutic massage for distinct body areas. Given respectability through its association with Medicine and the ‘sterility, objectivity and detachment’ (Nicholls and Cheek 2006, p. 2343) of the massage it promoted, the STM set up training centres around the UK framed about its London-based programme. Despite changes in its name to reflect an expanding scope of practice, the STM, now the Chartered Society of Physiotherapy (CSP), still produces a core curriculum about which all pre-registration programmes (degree access only since 1992) in the UK are developed. While the responsibility for validating these programmes currently falls to the UK Government under the auspices of the Health and Care Professions Council (HCPC), it is the CSP and its members, the profession of UK physiotherapy, that produce the National Curriculum Framework documents (NCF). Re-written every three to nine years these NCFs chart UK physiotherapy’s journey as a profession and the trends of therapeutic intervention technologies. Persistent across its history is a curriculum whose units / modules are focussed on the anatomy, pathology and treatment of body parts or systems and, more recently, an evolving prioritisation of the language of evidence-based problem solution (Higgs et al. 2001; Kell and Owen 2008). The definition of UK physiotherapy outlined in the latest (2002) version of the NCF is relevant to this study and states that

‘Physiotherapy is a health care profession concerned with human function and movement and maximising potential. It uses physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. It is science-based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgment and informed interpretation is at its core.’

(CSP 2002, p. 19)
ii) The pre-registration education of UK Physiotherapists

The CSP’s NCF (2002) sets out the underlying principles for UK qualifying programmes but provides ‘appropriate levels of freedom to programme providers to develop curricula according to their particular strengths and resources’ (p. 11). The main tenets of the NCF are that learners experience a student-focussed learning environment that values equally, and fully integrates, ‘learning achieved in university and practice-based settings’ (p. 25). The term ‘practice-based settings’ refers to the minimum of 1000 learning hours (or approximately one third of a pre-registration programme) that students spend away from the university learning new skills and ideas, and integrating existing, university-acquired learning, into real practice with patients under the supervision of qualified physiotherapists. Each university is free to organise the placement element of the curriculum in its own way as long as each student experiences ‘the core areas of contemporary physiotherapy practice … neuro-muscular, musculoskeletal, cardiovascular and respiratory’ (p. 28).

Throughout their pre-registration studies students are taught and assessed by State Registered Physiotherapists. While many academic staff on UK BSc(Hons) Physiotherapy programmes no longer practise patient-facing therapy, each will have studied an approved physiotherapy programme and be thus UK registered. In the placement setting students are usually placed with qualified therapists who act as their Placement Educators (PEds) for the duration of their rotation. University staff liaise with Placement Educators for students’ pastoral care, but take no part in the students’ placement learning. In most cases UK Placement Educators take on the role in addition to their patient-facing case load, without financial remuneration, as an expectation of their HCPC registration.

In summary therefore, within the framework of an eighty-five page outline curriculum, there is scope for both individual university and individual PEd variation in the way that pre-registration education is actually achieved. The focus of this study is the placement education component of physiotherapy education.

iii) Starting to think about how physiotherapy practice education is done

As discussed in Chapter 1, my interest in placement-based learning stems from my personal experiences as a UK registered physiotherapist who has both practised clinically and taught in a University and thus performed the roles of academic and PEd. Before my doctoral studies I had had no exposure to the language, ideas and interpretations of Social Science academia and the taught phase of the doctoral programme was both challenging and
empowering. One module introduced me to the work of Basil Bernstein and in particular his ideas about Pedagogic Discourse. Bernstein suggested that the production, transmission and reproduction of a discipline’s knowledge, practice and cultural values are a result of its pedagogic discourse (Marsh 2007). Pedagogic discourse was described as a collection of rules that operate within a society to specialise forms of consciousness (Bernstein 1990, p. 181) i.e. a group can unite itself and exclude others through its pedagogic discourse. Bernstein suggested that pedagogic discourse undergoes transformation, resulting from the interactions of key players in the field, as it passes from its production level (the macro level), through a series of recontextualisation fields (the meso level discourses) to its reproduction at the coal-face (the micro-level). The extent of the transformation will depend upon distinct features of each level and will reflect the dominant knowledge, practice and cultural values of the discipline.

The brief overview of UK physiotherapy pre-registration education discussed above illustrates the resonance between the structuralist perspectives of Bernstein’s ideas and the multi-tier influences of different physiotherapy groups on the reality of placement education experienced by individual students. The initial intention of this EdD project, and the focus of the proposal that went through the University and NHS Ethics Committees, was to explore the forms of professional identity, professional practice and expectations that are relayed during the pedagogic discourse of placement-based physiotherapy education. The proposal adopted Jephcote and Davies' (2004) model of three ‘levels’ of education-based societal structures influencing pedagogic discourses and, underpinned by an interpretivist perspective (after for example Hammersley and Atkinson 2007), suggested a mixed method approach to data collection as illustrated in Table 2.1.

Table 2.1: Outlining the plans and data sources for the EdD project as initially conceived.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Macro level: comprising the policy makers</td>
<td>Field of production</td>
<td>CSP Curriculum Framework authors</td>
<td>Document analysis: CSP NCF; HPC Standards of Education; QAA Subject Benchmark Indicator Statement.</td>
</tr>
<tr>
<td>Meso level: operating at the level of the academic institutions</td>
<td>Official recontextualising field</td>
<td>Specific BSc(Hons) Programme Handbooks created by senior staff. Speciality-specific placement education coordinators.</td>
<td>Document analysis. Interview and analysis of placement plans.</td>
</tr>
<tr>
<td>Micro level: representing the teachers at the interface with the students</td>
<td>Field of reproduction</td>
<td>Placement educators taking students on placement; Students; Patients.</td>
<td>Direct observation of real time patient-facing placement education. Post observation interviews of PEds and students.</td>
</tr>
</tbody>
</table>
The intention was thus to study the pedagogic discourse of physiotherapy placement education and explore the translation of that discourse as it moved through the levels of the profession’s societal structure to the real placement learning experiences observed being offered to a group of students. Ethical approval for the study was achieved in May 2009\(^2\) and permitted multiple access points to NHS clinical PEd staff and twelve days of direct student observation in hospital settings. The specifics of the study’s methodology and related methods will be the focus of Chapter 3. Here I emphasise that, at the point of entry into the field to conduct pre-observation access interviews with the therapists coordinating local placement education provision, it was my intention to describe how the pedagogy of placement education was enacted in practice. In the next section I discuss the troubles that emerged during the access interviews and the adjustments in study focus that resulted. The rest of the chapter will then ground the final version of the project in the literature of placement / work-based education research.

2.3 Troubles arising from an early focus on the pedagogic discourse of physiotherapy placement education – and some progress

i) Lessons in ethnographic familiarity

In July 2009 I conducted an audiotaped interview with each pair of senior clinical therapists who coordinated placements for visiting students in the two disciplines I was hoping to observe. The interviews were intended to elicit the pedagogy underpinning local placement education so that I could plan the forms of onsite data collection needed to record its enactment in practice. The discussions were also an opportunity for the staff to seek reassurances about the commitment of their colleagues in the study and its likely intrusion in clinical settings. The data relating to these interviews are presented and discussed in depth in Chapters 4 and 5. Central to my commentary here is the recognition, arising from my analysis of the interview transcripts, that my project proposal was underpinned by a misplaced assumption: that the pedagogy of placement education could and would be explicitly described and applied in practice. As will be evidenced in Chapters 4 and 5, I had fallen into the trap of ethnographic familiarity (Delamont 2002) and assumed, on hearing PEds using recognisable turns of phrase and expressions that I knew the practices to which they referred. By the end of the interview analyses it was clear that, while the PEds in each placement used similar words, the words had different meaning and value in each site.

\(^2\) Reference number: 09/WSE02/23
It is easy with hindsight to recognise the naivety and un-doctoral criticality with which I had engaged with the placement education and learning-related sociological literatures and arrived at this point of uncertainty at the very time in my project timetable when I needed clarity. With an admission reminiscent of that reported by Maxwell Atkinson (1978) and discussed in Chapter 1, I can see now how my initial project plans, despite using the words of an interpretivist perspective, were in reality ‘naively positivist in character’ (p. 4) and grounded in the science discourse of my discipline and training. The pull-up moment after my first fieldwork interviews was very real and left me almost bereft of direction and purpose. Reflection on my predicament suggested that the majority of the physiotherapy placement education studies I had read and conducted were built on the assumption that UK physiotherapists knew how placement education was done. Unwittingly mirroring Atkinson’s journey, and supported by my supervisors, I entered repeated cycles of ‘reading, researching and writing’ (p. 6) and revisited the physiotherapy placement education literature with a more critical stance. In the next subsection I orientate the reader to this literature to foreground both the change in focus of the resultant project and my claim for its originality in the context of UK Physiotherapy education.

ii) Revisiting physiotherapy placement education specific literature

A synthesis of the accessed physiotherapy placement education literature suggested that the studies had been undertaken by physiotherapists with the majority based within academic teams. The studies appeared to fall into the following five distinct groups of research focus:

- the structure and mechanics of placement provision (Baldry Currens and Bithell 2000, 2003; Moore et al. 2003);
- how students and/or placement educators could be supported to maximise the learning potential of the placement (Cross 1998; Kell and Jones 2007; Bennett 2008; Mooney et al. 2008);
- what students learn on placement (Geddes et al. 2004; Lindquist et al. 2006; Kell and Owen 2009);
- how placement education is created from the placement educators’ perspective (Scully and Shepard 1983; Ohman et al. 2005; Kell and Jones 2007) and
- how the three people involved in placement education sessions (the PEd, the student and the patient) create learning opportunities for the student (Laitinen-Väännänen et al. 2007).
The frequency of phenomenological- and grounded theory-informed approaches used in these studies suggested that the researchers were aware that their specific research foci were poorly understood or newly considered, and no author articulated the pedagogy underpinning the placement education practice they studied. As in Atkinson’s (1978) observations of the existing suicide-related literature he reviewed in his own doctoral studies, there was a strong sense of positivism underpinning the studies with little cross-project integration or development. Indeed two systematic reviews of placement education research note the fragmented approach to the published research and the challenges for the profession of building on previous studies and putting recommendations arising into practice (Baldry Currens 2003; Lekkas et al. 2007). With the exception of Scully and Shepard’s nonparticipant observation-based ethnography (1983) and Laitinen-Väänänen et al’s video-based observations of discrete episodes of placement education (2007), the dominant methods of data collection used in the physiotherapy studies were participant interviews and questionnaire surveys. Whether explicitly or implicitly, the researchers (including ourselves) had adopted, or assumed, a cognitive perspective of learning to frame their enquiries. The consistency of this observation provoked a critical revisit of the educational psychology literature. The key learning points arising from this critique are discussed in the next section.

iii) Theories of learning and their relevance to this project

Studying learning through a lens of cognitive psychology drives research that frames questions in terms of how learners mentally structure and organise their thinking as they learn. Research adopting a cognitive perspective of learning draws on the work of for example Vygostsky (1962), Piaget (1985) and Ausubel (1968), to explore how learning can been enhanced by learning environments structured in ways that scaffold (Vygostsky), stage (Piaget) or hierarchically organise (Ausubel) new learning. In the context of physiotherapy placement education such studies claim to have identified learning, thinking and professional identity characteristics arising as a consequence of placement education experiences (Geddes et al. 2004; Lindquist et al. 2006; Kell and Owen 2009).

The work of Norwegian researchers Skøien et al. (2009) stands out from other physiotherapy placement research by explicitly adopting a social perspective of learning. Social learning theory shifts the focus of enquiry from the individual and their mental structures (the cognitive perspective) to the sociocultural setting and the activities of the people in that setting. From a social learning perspective learners interact with others and the environment in a ‘co-constitutive process’ in which all participants change and are transformed through their actions and relations (Driscoll, 2005 p.159). Within the
physiotherapy context Skøien et al. (2009) suggest that adopting a social perspective of learning enables researchers to view students as complex individuals with multiple identities that reflect the influences of the multiple social groups to which they belong.

Particularly influential in Skøien et al.’s work was Lave and Wenger’s (1991) notion of situated learning. Located within social learning ideas, Lave and Wenger (1991) describe learning as ‘an integral and inseparable aspect of social practice’ (p.31) in which learners, through practising with and alongside the expert practitioners of their specific learning community, ‘both absorb and are absorbed into the culture of practices’ (p. 95) they experience. Additionally Lave and Wenger suggest that, while opportunities for learning in any given setting may be mediated through social interactions, the interactions and the learning opportunities themselves are characteristics of the community within which they are situated. Learning is thus conceived as being ‘an integral part of generative practice in the lived-in world (Lave and Wenger 1991, p. 35) and related to and located within the community’s values, culture and histories (Korthagen 2010).

Lave and Wenger (1991) use the term ‘legitimate peripheral participation’ (p. 29) to refer to the process by which newcomers become members of a specific social group or community of practice, and describe the ‘conferring [of] legitimacy [as] more important than… providing teaching’ (p.92). Building on Lave and Wenger’s ideas Gherardi (2006) suggests that, through seeing and practising context-specific professional activities, students learn to ‘move, speak, use instruments and establish social relations appropriate for the competent reproduction of those practices’ valued in the local setting (p.228). In this discussion learners, through their legitimacy to practise even peripherally, are recognised as co-producers of their group’s practices and can expect to have their ‘newcomers’ contributions … taken into account’ (Lave and Wenger 1991, p. 117).

From a situated learning perspective therefore, students are viewed as essential elements of the practice environment who, as co-practitioners, have potential to exercise their agency to change or perpetuate the knowledge and learning of their society. Gherardi, in her observation of construction work site manager apprentices, suggested that while ‘novices differed in their ability to see opportunities to engage their educators in discussion about practice rationale’ (2006, p. 122), some saw the potential to raise ideas but chose not to on the basis of their perception of ‘constraining’ or learning controlled environments (p. 228). Similar studies of work-placement learning for teachers (Abrandt Dahlgren and Hammer Chiriac 2009) and doctors (Spilg et al. 2012) report learners’ alertness to perceived environmental constraints and a choice-making with respect to using their participant-
afforded agency to question observed practices and support profession growth, or using their agency to withhold that contribution.

In the context of the current study, while there were resonances between my experiences of physiotherapy placement education and the ideas of legitimate peripheral participation (for example students working with real patients alongside their educators because they are students on an approved course), little work to date explores physiotherapy practice in this way in naturally occurring placement settings. The ideas of both social and situated theories of learning afforded potential to explore how learning in a physiotherapy placement is socially accomplished, the possible situated features of that learning and students’ use of their agency in placement settings. Firstly however, my challenges were to understand what ‘social participation’ looked like and how its enactment could be captured as evidence in the field. In the next section I explore these problems through the physiotherapy-specific literature focusing on therapist: patient interactions in practice settings.

iv) Lessons on ‘interactions’ from the physiotherapy: patient interaction literature

Conceiving placement education as social interaction-based learning made relevant a body of physiotherapy literature exploring the interactions between physiotherapists and their patients in therapeutic settings. Reporting studies framed in ethnographic (e.g. Richardson 2006), grounded theory (e.g. Edwards 2000), and hermeneutic phenomenological (e.g. Ajjawi and Higgs 2008) approaches, the physiotherapy interaction papers appeared more coherent as a whole and written from a more interpretivist, uncertain and questioning perspective than the placement education literature. Explicitly underpinned by sociological theories and perspectives, the researchers typically used video to record the interactions they studied and interviews, not as stand-alone data sources, but to hear the participants’ rationale for their observed performances. Data analyses commonly adopted content (e.g. Thornquist 1994), discourse (e.g. Talvitie and Reunanen 2002) and conversation analysis (e.g. Parry 2004; Martin 2009) approaches.

Rich in fieldwork data extracts, the literature brought physiotherapy: patient interactions alive so that I could feel and sense the reality of the interactions being described. Researchers illustrated for example how therapists’ use of touch and talk (Roger et al. 2002) or movement and associated talk (Thornquist 1994; Jorgensen 2000; Talvitie and Reunanen 2002; Parry 2004; Martin 2009; Parry 2009; Martin and Sahlström 2010) were in and of themselves working to create the interaction as physiotherapy. Edwards (2000), for his PhD study, recorded, as written case studies, the verbal and nonverbal (touch and movement-based)
elements of the therapist: patient interactions he observed and used these to illustrate how an interaction was created by much more than the words spoken by the participants. Martin (2009; Martin and Sahlström 2010), in her longitudinal study following one shoulder patient for 9 months and 22 separate therapy sessions with one therapist, used video to record the interactions she observed and adopted a conversation analysis approach to unpick the verbal elements of the data and map them to video stills of the patient’s accompanying movement. The richness of Martin’s data and the depth of her discussion brought physiotherapy patient interactions to life in ways I understood so that, by the end of her papers, I could see how her subject’s learning was evidenced in their ‘embodied talk’ (Martin 2009, p. 134).

While opening up a world of possibilities for my project, the studies’ results and discussions also had things to say about physiotherapy practice that were uncomfortable reading for me as a physiotherapist. I comment on these briefly here because the studies had a major impact on ensuring that the data in my own study paid due attention to all participants in the physiotherapy education setting including the patient about whom that practice orientates. Consistently physiotherapy: patient interactions were described as therapist controlled (Parry 2009), task-orientated (Roger et al. 2002) and framed in technical rational or mechanical views of body (Jorgensen 2000) and ‘normal’ health discourses that emphasised the ‘segments’ of the patient with ‘potential to change’ and improve towards ‘normal’ with physiotherapy-relevant interventions (Beeston and Simons 1996, p. 235). Further, all studies explored the role and impact of the patient in the two-person interaction and, noting the little (if any) space for patient agency and personal story-telling (Talvitie and Reunanen 2002; Parry 2009), described how the task-orientated focus of the therapists placed patients in a passive role as ‘body-object’ (Thornquist 1994, p. 711) with their ‘lived bodies’ receding into the background (Jorgensen 2000, p. 112) as the therapists constructed data to create ‘solvable physiotherapy-relevant problems’ (Thornquist 1994, p. 709). These studies add weight to the reports in a student placement reflective diary-based project that students regularly saw therapists treating ‘patients as commodities’ (Geddes et al. 2004, p. 23).

Parry’s work using conversation analysis to study video recordings of neurology-based therapeutic interactions tries to unpack these consistently observed therapeutic: patient interaction patterns (2004, 2009). She suggests that therapist control and patient acquiescence is a deliberate therapeutic strategy to co-produce an interaction that enables patient and therapist to ‘protect one another and the therapeutic process as a whole from the problematic and threatening implications which might arise from episodes of physical incompetence’ (2004, p. 1001). Parry concludes that therapists, supported by the
compliance of their patients, create interactions as performances in which ‘physical failures’ are treated as ‘solvable matters’ for physiotherapy (Parry 2009, p. 850).

When asked about the rationale for their practice however, the research consistently reports therapists’ intentions to create patient-focussed interaction practices underpinned by a commitment to holistic patient-specific care that appears at odds with observed practices. The apparent mismatch in accounting and observed interaction practices reported in these studies resonates with another body of literature, originating mainly in Australia, which seeks to understand the processes by which physiotherapists reach patient-specific treatment decisions. A short foray into this literature is essential to help readers understand the context of physiotherapy practice before the main study is described.

v) Thinking about how physiotherapists make therapeutic decisions

The way physiotherapists make decisions about the care they offer is known as clinical reasoning (CR) and is said to be associated with personal conceptions of body and health. Trede and Higgs suggest that therapists who believe that their role is to provide physiotherapy to a patient within an ‘illness’ model of health, adopt a cognitive science based, clinician-centred, empirical-analytical, patient-as-passive-recipient CR approach (2008). Edwards et al. (2004) and Higgs and Jones (2008) describe two models of cognitive-science-based CR that are common within physiotherapy: hypothetico-deductive (HD) reasoning and pattern recognition. Edwards et al. combine these two models under the umbrella term ‘diagnostic reasoning’ to recognise that expert therapists use either model depending on their familiarity with the patient’s presenting problem (Edwards et al. 2004).

In contrast, therapists who adopt a ‘wellness’ or ‘capacity’ model of health are said to hold an interpretive underpinning philosophical paradigm which is reflected in a practice that empowers patients to own the therapeutic interaction (Trede and Higgs 2008, p. 34). Therapists with an interpretive philosophy have been shown to adopt a narrative CR approach in which the patients’ own story, or narrative, of their lived experience of their problem(s) grounds the therapist’s reasoning process (Edwards et al. 2004). Martlew (1996), describing the work of a hospice-based therapy team, suggests that health workers adopting this perspective ‘listen sensitively’ (p. 564) in a way that strives to glean the patient’s perspective in each unique context. Therapists use their experience to make suggestions, but it is the patient who decides and thus owns the strategies adopted to help them achieve personally meaningful goals. As Edwards et al. (2004) point out, narrative and diagnostic reasoning models share key practice and cognitive elements e.g. hypothesis generation and
testing, but differ in the positioning of the patient and their relative agency in therapeutic interactions.

The clinical reasoning literature relates to the interaction studies discussed in the previous subsection because the former has concluded consistently that physiotherapists neither notice nor try to articulate and question the assumptions or epistemologies upon which their interaction practices are founded. In their review paper Edwards and Richardson (2008) argued that ‘understanding practice epistemology is not an academic exercise but is instead fundamental to understanding the kinds of data gathering and decision making required for problem formulation and collaboratively determined management strategies with diverse healthcare populations’ (p. 184). However, in practice, Trede and Higgs (2008) described expert physiotherapists accounting for their decisions with ‘theories, guidelines and professional training’ in which ‘the ideology behind those theories and training remain(ed) hidden’ (p. 33). These findings replicate Turner and Whitfield’s earlier observations that their sample of UK and Australian physiotherapists were using ‘recipe-like reasons’ to justify their practice decisions (1997, p. 25). Such blindness to underpinning practice assumptions, possible alternatives and opportunities for discussion and reflection are major impediments to practice change following the changes already apparent in the rhetoric of healthcare provision (Jones et al. 2006).

The call to physiotherapists to be explicit about their decision making assumptions is not new. In her seminal reflection on the work of physiotherapy, Joyce Williams, a former Chair of the CSP Council, described her profession as ‘a mint with a hole in the middle’, a profession unable to articulate its core (Williams 1986, p. 68). Similarly, in Sweden, Tyni-Lenné (1989) asked her colleagues what the profession had to gain by ‘clinging to data without theory’ (p. 169). The literature reviewed here suggests that while physiotherapy-specific clinical reasoning and patient interaction research have burgeoned, there has been little impact on UK education and practice.

The challenges to change illustrated here are reminiscent of those of professions Kuhn described as ‘emerging science’ professions (1996, p. 17). The physiotherapy profession depicted in the literature conforms in some ways to the definition of an emerging science with the apparent invisibility of its underpinning paradigm and reliance on positivist research published in specialist scientific journals that seek to legitimise its practice as evidence-based (p. 19). In other ways however, physiotherapy may be described as an established science. The literature reviewed in the last few sections illustrate practice consistency indicative of a profession that has ‘assimilated a time-tested and group licensed way of
seeing…(and) has embodied a way of viewing physical situations, … its tacit knowledge learning, by doing science, rather than referring to rules and laws’ (p. 189-190) to solve its puzzles. The literature also suggests that therapists worldwide are noticing that living patients are the focus of physiotherapists’ ‘puzzling’ (p. 205), and questioning the profession’s practice assumptions. Taking Kuhn’s ideas one step further suggests that physiotherapy may be on the cusp of a ‘revolution’ of its world view (p. 111). If increasing numbers of therapists believe that the existing, invisible paradigm of practice is ‘persistently failing to solve a noteworthy puzzle’ (in this case patient-focussed physiotherapy), then there is potential for a new paradigm both to emerge and for its testing to be tolerated against its predecessor. In short, if enough therapists engage with social science discourses and look at physiotherapy through different lenses, the patient and their place in twenty-first century UK interactions could become the focus of education attention.

These observations and reflections offer head-spinning research potential and both excited and dramatically changed the focus of my ‘noticing’ for the current project. What were students observing on placement? Could adopting a social learning perspective of education help me notice and make visible for others what students do on placement and how they show their learning to the placement educators who conduct their summative placement assessment (Bennett 2008; Mooney et al. 2008)? In practice do they do as they report in their personal diaries and, ‘despite conflict with’ themselves (p. 24), ‘conform to the practices of their educators’ (Geddes et al. 2004, p. 23)? To explore these ideas I needed to engage critically with a range of placement and work-based learning research conducted in non-physiotherapy settings. The critique forms the basis of the next section.

2.4 Observations and reflections from reading non-physiotherapy-focussed workplace learning research

i) Further ‘ah ha’ moments and making choices about what to discuss here

This section recounts the key learning points that arose from a critical review of a seam of the workplace learning research selected as a consequence of my reflections on the physiotherapy-specific interaction and placement education research. Specifically, and with the guidance of my supervisors, I read a range of research exploring learning across a breadth of disciplines and learner age spectrum. I focussed the review on research that had adopted social and situated learning perspectives of education and was grounded in observation of learning in practice settings.
These readings resulted in a transformational change of my life view and research perspective. Brew’s (2001) phenomenographic study of researchers’ conceptions of research provided an anchor and reassurance that this second, and deeply felt emotional wobble (as a challenge to my understanding about who I was as a person, therapist, educator, researcher etc.) was to be expected and indeed celebrated among researchers who adopted a ‘journey’ conception of research (p. 280). Privileged to be able to enrol on a professional doctorate programme for personal development and free from implicit or explicit ties of disciplinary allegiances, I have had the freedom to be ‘transformed through the process of engaging in it’ (p. 280). The key transformational episode however was so complete and unexpected that I remember clearly where I was and what I was reading when the scales fell from my eyes. As other researchers have described, once the scales had been removed and I could ‘see’ more of the complexity of social interaction research, I could not go back. There is no space here to do justice to the plethora of ‘ah ha’ moments that followed, so I have taken the decision to focus the discussions in this chapter on the education-focussed literature and draw on the social interaction research as their findings resonate with later discussions about my own project results. Suffice here to note that I had ‘seen’ how every interaction [as distinct from an encounter (Strong 2006a)] required each participant to demonstrate their engagement in the interaction through their manipulation of the resources to hand (their talk, body movement, eye movements, use of interaction space, manipulation of artefacts for example) in ways that were expected and recognised by their interaction co-participants as appropriate for the interaction being collaboratively performed (Garfinkel and Sacks 1970; Goffman 1972).

Most profound for me, as a physiotherapist, was the recognition that my trained-in objectivist conception of human movement framed as joint angles and muscle work (Farnell 1999) set in a ‘mental image of movement-based “normality”’ (Rose 1999, p. 145), had blinded me to the wealth of information about my patients that the subtleties of movement, when viewed through a social interaction lens, could have made visible. If I wanted to study students’ learning experiences, and I believed that learning was a ‘running together of doing and being’ (Dingwall 1976, p. 338), I needed to learn more about, and find a way of recording, the minutiae of how learners ‘do’ learning in practice settings. This rest of this chapter section thus focuses solely on explicit learning-based research. In the next subsection I discuss the key learning points from my reading of non-health-based research. Additional

observations and relevant lessons for my project arising from the health-based studies follow in subsequent sub-sections.

ii) Lessons in archaeology, prostitution and science: learning as a practical accomplishment

In this subsection I draw on observation-based research of learning in five different contexts and the work of Giddens (1991) and Goffman (1969, 1972) to explore both the complexity of placement education facing students and the features of the placement environment that can affect students’ learning. Specifically the discussion is framed about the following non-health-based practical learning studies: Lynch and Macbeth’s observation of American primary school children’s science classes (1998); Goodwin’s study of archaeology students on a fieldwork placement (1994); the education of a ‘Madam’ (Heyl 1979); the construction-site based learning of building-work related professionals (Gherardi 2006); and the workplace learning of high school teachers (Little 2002). Each of these studies adopted a social perspective of learning which they described as taking place in the ‘flow of experience’ where the students ‘knowing and doing were one and the same’ (Gherardi 2006, p. 14). Learning was thus conceived as a practical accomplishment made visible through the learners’ naturally occurring interactions (Little 2002).

Despite the students’ immersion in the context of their learning through their living in the ‘House’, it was not possible for Heyl to observe the practical work of apprentice prostitutes, and her study relied on their and their clients’ accounts (1979, p. 123). In all other cases learning was described as being evidenced by the students’ ‘little performances’ as they endeavoured to maintain the ‘with’ or togetherness that identified them as in an ‘ecological proximity’ with their educators and detached from groups of interaction practices going on about them (Goffman 1972, p. 41). Central to Goffman’s idea of a ‘with’ is his observation that students aim to create a ‘viable image’ of themselves in the eyes of their peers and assessors. Foundational to Goffman’s work is the idea that students are agentic in the ‘dramatic realisation’ of the image of self they portray, and that their goal, in an interaction perceived as hierarchically constructed, is to ‘make a showing’ or engage actively ‘in impression management’ in ways that project the interaction performances they think their educators expect (1969, p. 26).

It is testament to the remarkable capacity of the human mind that, with each ‘with’ in which the student engages (their family, friends, educators, assessors etc.) ‘elaborating and transmitting the codes of appropriateness of a disciplined body and the criteria of aesthetic
evaluation of successful work (interaction) performances’ differently (Gherardi 2006, p. 98), students can deconstruct the web of practices within which they find themselves and reconstruct them as appropriate practical actions in each setting. With each social group having its own expectations of how students should move, speak, use artefacts and look at the focus of their work, facets of interaction performance are not conducted in isolation and students must combine the required elements to make an acceptable whole in each context. Thus while, as in Lynch and Macbeth’s observation of young children learning classroom science, the students’ ‘concerted ordering of eyes, ears, hands, entire bodies, equipment and discursive actions’ (1998, p. 277) can be facilitated by the skill of the teacher, the students have a challenging task to learn to manage their interaction practices to project to others impressions of specific community membership.

A further complexity of interaction performance occurs when the interaction requires appropriate manipulation of specific artefacts or tools. Goodwin used the term ‘professional vision’ to describe the ‘what it is’ that students should be looking at and acting on in order to use artefacts in a context-appropriate way (1994). In his study of archaeology students on a field trip, Goodwin describes an educator completing a soil composition record sheet from measurements reported by their student whose use of a tape measure and other data collection tools they have observed. The ‘with’ of the two participants was said to form ‘a small activity system that encompasses talk, writing tools and distributed cognition’ that enabled the student to ‘see in the earth’ what her profession required her to see (p. 612) and report it using the ‘talk and gestures’ that were both ‘relevant to the specific game,… and embedded within the larger activity of doing archaeological fieldwork’ (p. 614).

Collectively therefore, the studies, through the richness of their interaction transcripts, and particularly the inclusion of video stills in both Lynch and Macbeth’s (1998) and Goodwin’s (1994) papers, emphasised the need to capture the detail of not only the verbal- but also the kinesics- (nonverbal communication-related body movements), proxemics- (presence within and use of space) and haptic-based (touch) elements of each interaction participant’s performance in order to reflect as accurately as possible the ways in which physiotherapy placement education is practically accomplished. Focussing on each participant’s performance, and not just those of the student, makes visible the impact of educator ‘surveillance’ on student performance and thus learning. Goffman's ideas about student practice ‘easefulness’ (1972, p. 295), conveyed through the smoothness and ‘accomplished normalcy’ (Giddens 1991, p. 129) of their actions, are relevant to this discussion. Goodwin for example describes the chart completion activity he observed as indicative of an empowering form of educator surveillance that enabled the student to question what the
educator was asking her to do, and thus expose, openly, the development of her professional vision in that specific learning context. Having illustrated the student’s ‘easefulness’ through verbal, kinesics and proxemics elements of her interaction with the tutor, Goodwin describes the outcome as a ‘collaboration’ between the participants (p. 612).

In contrast, where there is a perception of sanction resulting from poor performance under surveillance, students are challenged to make a decision about how to perform. In Gherardi’s study building construction students were observed slowing down the performance of both the physical and verbal elements of their skill practice in a way that appeared to enable them to gain more feedback from the nonverbal elements of their educators’ response to their on-going performance (2006). Similarly, both Heyl and Clouder, (in her study of occupational therapy students where placement learning assessment had beyond-placement implications) discuss students’ real or reported interaction practices being ‘shaped into conformity’ (Clouder 2003, p. 220) by their endeavours to ‘avoid provoking censure’ (Heyl 179, p. 137).

While many of the features of the learning environments described in these studies resonated with the practices I anticipated observing in the field, the majority focussed primarily on hierarchical interactions with an explicit member / learner distinction. Little’s study of teacher learning added a further dimension by exploring within-group learning-focussed interactions (2002). In her paper, Little reproduced a word-based transcript of verbal and some gesture-based non-verbal elements of 18 minutes of a group learning activity for practising teachers. The difference between Little’s study and the others discussed in this section is that the talk of the ‘like’ professionals is based on assumptions of individual participant similarity because of their equally ‘qualified’ status. Such assumptions of shared understanding renders the thing the teachers are talking about (here classroom practice) ‘relatively opaque’ (p. 932) to non-insiders with large sequences of the data incomprehensible to me without Little’s analytical support. In hindsight of course, falling into assumption-based talk is precisely the mistake I made during my access interviews with the placement educators. My interviewees knew that I was a therapist and, using a shared language, we engaged in 60 minutes of conversation with all of us assuming that we shared an underpinning meaning and value system. Student physiotherapists on placement spend time alone with their PEd and patient in education-focused interactions, but also experience the everyday bustle of group-based networking interactions. Little’s paper helped me to notice that each interaction with which students participate on placement has learning potential and should be recorded to capture the richness and diversity of the naturally occurring interactions they experience.
In sum therefore, a reading of non-health education-related research honed the view of interaction practices that I took from the physiotherapy literature and enabled me to get a better feel for the shape of the field of enquiry I wanted to explore. With a more mature sense of the complexities I was likely to face pursuing an observation study of placement education, I returned to the health-related work-based education literature to focus both on how the research in these settings had been done by others, and how educator: learner interaction practices were influenced when the key ‘artefact’ in the healthcare context was a living patient. The next subsections offer a limited critique of the related research and its influence on the final development of my research focus.

iii) Teaching, learning and healthcare: incompatible agenda?

Health-related work-based education research reflects the division of healthcare work in major Western Societies i.e. that work provided by doctors and that provided by the non-medical professions known variously as ‘health and care related’, ‘allied health’ or the ‘professions allied to medicine’ (HCPC\(^4\)). In the UK, pre-registration medical programmes cater for hundreds of students and offer curricula that explore the diagnostic and therapeutic work of doctors relevant to each part, system and pathology of the human body. The allied health professions like physiotherapy, are smaller, numerous in number and focus their work and curricula on a specific aspect of human care.

The difference in the size and significance of medicine over its related healthcare professions is reflected in the attention that has been paid to the education of its students by sociologists who are not themselves medical doctors. Elements of this non-practitioner generated research informed the focus of my study and will be discussed first in this section. In the allied health context (ie non-nursing healthcare professions) research is more fragmented and practitioner-generated. These insider-conducted observations of work-based practices cast a different lens on learning. I explore key papers in this literature as a group in the second subsection below.

a. Observations from sociologists’ studies of clinically-based medical education

Medical students’ learning in clinical settings, as an exemplar of professional education practice, received much attention in the 1970s with the publication of seminal observation-based studies by sociologists in both the USA (for example Becker et al. 1977) and the UK

(for example Atkinson 1975). These and other studies have spawned a wealth of related research, bespoke journals and global conferences focussed on medical education. Within the diversity of published research are studies focussing explicitly on how face-to-face learning in clinical settings is actually done. In this subsection I discuss a small number of projects that placed learner interactions with their teachers in the observation frame and consider how this work informed my approach to the current study.

An element of Atkinson’s extensive ethnographic observation of the clinical phase of medical students’ training followed groups of students on ward-based placements. Despite the scenes he observed involving about 8-10 people, Atkinson described the ‘most distinctive feature of clinical teaching’ as its ‘triadic’ nature (1975, p. 170). From his perspective the teacher-led interactions Atkinson observed were comprised of three interaction participants: the doctor, the patient and the students who, though many, ‘were tied to each other to produce a single actor’ (p. 172) in the learning setting. Atkinson described all three groups of interaction participants performing a specific role to affect the learning context as identifiably that expected of medical education in each setting. Conceiving learning interaction as the three-way performance of roles (taken by or given to participants) added a new dimension to my thinking about work-based learning and I explore this further below.

Strong’s classic studies, observing medical interactions when students (or other observers) were and were not involved in doctor: patient interactions, were influential in my thinking about the role(s) patients play in physiotherapy learning interactions. Strong used his fieldwork data to both explore the ‘sorts of identity tacitly claimed by each party and conferred upon the other’ (Strong 2001, p. xi) participants in interactions, and to look behind the performance playing out before him. Strong challenged me to question not only what the members of the interaction where doing and what role their doings might effect on the continuation of the triadic interaction, but also to question whether the outward show was actually ‘clothing other matters’ that may or may not be aligned with the intentions suggested by the immediately obvious outward showing (p. xii). Although complex to write down, I will illustrate my interpretation of Strong’s ideas and their impact on the stance I tried to adopt in my own study using examples from his and other’s work. In so doing I evidence my growing awareness of the subtleties of interactions that render patients, the necessary learning resources of students, as variously empirical instances of types of phenomena (Atkinson 1975) and objects to be ‘taught on’ (Strong 2001, p. 164) or ‘taught from’ (p. 167).

---

5 Readers should note that I have used the second edition of Strong’s book. The original work, published in 1979, was contemporaneous with Atkinson’s 1975 study.
Atkinson described several environments in which he observed students learning on placement. One of these, the bed-side teaching environment, was dominant in the medical-ward based element of his study. Teaching by one doctor to a group of students arranged around a patient lying on their bed typified a form of teaching the students labelled as ‘cold’ medicine. In this setting the doctor ‘taking’ the group of students identified a patient as the focus of the teaching session. The patient in a ‘cold’ medicine teaching session had already been ‘diagnosed’ and begun appropriate therapy under the direction of the qualified medical team. The students’ role in this interaction was to draw out of the patient details about their condition, and work through ideas about possible diagnoses and treatment recommendations. Atkinson and Delamont described bedside teaching as ‘reproductions’ of medical reality used for teaching purposes only and distinct from any additional therapeutic interactions the doctor may have had with that patient (1977, p. 105). While these bespoke patient-present teaching sessions did not resonate with my own experience as a physiotherapy student or placement educator, they served to illustrate one perspective of Strong’s ideas in action: the patient in the outward role of agentic actor clothing or masking his position as an ‘empirical exemplar’ as I discuss below.

Atkinson describes the bedside teaching interaction as an ‘information game’ with participants involved in a ‘sequence of moves aimed at the management and control of information’ (1975, p. 179). In the triadic, cold medical education game some participants (the patient and the doctor) have information which others (the students) need to elicit in order to show that they can manage the uncertainty of multiple diagnosis possibilities and cope with the ‘puzzling questions’ of their profession (Fox 1975, p. 87) in the way expected by the locally qualified staff. In the context of the bedside teaching session, Atkinson suggests that the patient and doctor together ‘make observable, teachable and reproducible the methods whereby… things are normally done by competent members’ of the local team (Atkinson and Delamont 1977, p. 104). From Atkinson’s perspective the patient is an active ‘social actor’ in the interaction that unfolds (1975, p. 170).

Strong’s work offers a different interpretation of the role of the patient in this interaction. Strong studied doctor: patient interactions in outpatient clinic-based settings. When students were present in the clinic they experienced what Atkinson’s students (1975) described as ‘hot’ medicine with the supervising doctors co-incidentally participating in therapeutic interactions with their patient and teaching interactions with their students. Unlike their ward-based teaching interactions, doctors in clinic have no control over the learning-usefulness of the cases presenting at each session and teach ‘from whatever happened to turn up’ (Strong 2001, p. 167). Strong describes the students’ presence as having an ‘audience effect’ (p.
on the therapeutic interaction. Quantitatively he describes the reduction in time a doctor spends talking to the patient when students are present. Qualitatively, through field note records of the interaction participants’ verbal and non-verbal communication practices, Strong illustrates how the clinic patients are both disempowered and turned into ‘teaching material’ as if ‘auxiliaries to a floating classroom’ (p. 167) by the presence of students in their consultation. Strong writes of doctors seeking consent from their patients for the presence of students, in ways that renders a negative answer impossible to give, as foregrounding a shift in claimed and assumed interaction roles. He describes the shift in interaction roles as effectively ‘undercut(ting) the idealised version of a private, confidential and uniquely focussed relationship’ (p. 164) a patient might expect, into one that is implicitly available for later discussion when some, but not all of the interaction participants are present. Further, despite the reported reluctance of many doctors, Strong evidences their breaking into ‘collegial discussion’ with their students about the patient in ways that prevented both patient participation and agency. Strong’s attention to the minutiae of interaction practices evidences a mismatch between the projected image of an interaction focussed on patient care, and practices that translate the interaction from one focussed on ‘a patient with a problem’ to ‘a problem students are obliged to learn about’ (p. 108). The vivid nature of Strong’s field notes resonated with my experiences of ‘hot’ physiotherapy education and challenged me to question both how such interactions were constructed as physiotherapy and not medicine, and also what ‘matters’ about physiotherapy assumptions their student-present interaction practices might ‘clothe’.

Finally in this subsection I discuss a twist on the medical education research: learning in a triadic interaction when one participant (the patient) is unconscious. This form of triadic interaction was the typical learning context observed by Pope et al. (2003) in their ethnographic study of trainee anaesthetists’ learning in practice. Pope et al. suggest that the removal of an active, role-playing third interaction participant, unclothed the interaction to expose the learning that actually goes on in clinical settings. Pope et al. describe senior anaesthetists (the teachers in this setting) struggling to ‘make visible the elements of skills that for them are imprinted on their brain, eyes and hands… (and) automatic’ (p. 652). Like the other ethnographers discussed in this Chapter, Pope et al. used details about the minutiae of participants’ verbal and nonverbal interaction practices to demonstrate that, in reality, it was not the skills of their trade that the learners were learning, but rather the ‘tacit knowledge’ about how such practical skills were locally accomplished. Further, in an interaction where there was no attempt to engage the patient in anything other than a learning resource role, Pope et al. described the intense focus of the teacher on the learner, and what she described as the ‘tension between’ the learner’s ‘following’ and their exerting
their own style on the technique being taught (p. 652). Resonating with Fox’s (1975) observations of how medical students learn to deal with the multiple uncertainties of their practice, Pope et al. described how learner performances that ‘show’ confidence and certainty and had greater impact on the progression of the teacher: learner interaction than the quality of the skills’ manual performance.

The studies discussed here have made visible the complexity of triadic medical education interactions and thrown into relief the assertions that clinical education is about ‘applying, consolidating and reflecting on learning gained in the university environment’ (CSP 2002, p. 27). Despite researching very different education settings, the work of both Strong (2001) and Pope et al. (2003) supported the observations from non-healthcare education settings that practice-based professional education is about the promulgation of tacit professional values. The research here suggests that in medical settings the values being promulgated make the exclusion of the patient in their healthcare choices both invisible and acceptable. The relevance of these ideas to the research from other allied-health professions’ work-based education practices is discussed below.

b. Observations from allied-health practitioners’ research into their profession’s practice education

In this subsection I discuss research that observed work-place learning in four distinct allied health professions: Social Work (SW), Health Visiting (HV), Neonatal nursing and Speech and Language Therapy (SALT). When I first explored this research I read the books and journal articles in random order interspersed by other readings, writings and reflections. My notes from that time suggest I noticed only the researchers’ confirmation of my own assumptions of the explicit distinctions between the professions. For example the research suggested that the work of Health Visitors and Social Workers was centred on the oral histories of their ‘clients’ with learner-professionals able to visit their clients alone without the direct supervision of a qualified colleague (Dingwall 1977b; Pithouse 1998). Similarly anticipated were the observations that SALT education and neonatal post-registration nursing emphasised the practice of profession-specific skills on ‘patients’ under the direct supervision of a named educator (Higgs and McAllister 2007; Hunter et al. 2008).

Re-reading the texts as a group evidenced cross-profession work-place learning practices that resonated with the ideas generated from the medicine-specific research discussed above. Thus the SW students’ collection of data from remote patient sources and their oral re-creation of that patient as a ‘practically constructed and approved reality’ in the presence
of their seniors (Pithouse 1998, p. 52), aligned with Atkinson’s descriptions of medical students’ away-from-the-patient group tutorial learning practices (Atkinson 1975). These practices of student groups learning the conversion of patient-generated data into encoded and acceptable written records and then re-coding them to verbalise the case for the profession’s work made by those notes, were evidenced within each profession’s work-based learning interactions. Dingwall for example, identifies ‘information management’ as the heart of HVs’ work with students (themselves qualified nurses) learning not only to convert patient data into records, but also to pass these on to other HVs in certain specific ways, before these HVs in turn pass on their cases to others in an internal professional ‘ritual of handing over one to another’ (p. 86). Similarly Hunter et al. (2008) in their observation of neonatal specialist nurse training describe qualified nurses, who have learnt to write notes in other settings, learning the important elements of local note-writing practices where computer-based records are shared by all members of the multidisciplinary team caring for an individual infant.

Central to the observed learning in each professional context is thus the students’ participation in the talk and record-generating activities of their seniors so that, through observation, practice and feedback they ‘learn the interpretive scheme which holds currency’ in their specific community of practitioners (Dingwall 1977b, p. 113). In each study the researchers use their careful ethnographic observations of the practices of educators and learners in workplace settings to suggest that it is the tacit, invisible knowledge about the assumptions and values underpinning locally-specific professional performances that frame the core placement learning and not the students’ practical skill development per se.

Dingwall and Hunter et al.’s research added a further dimension to the discussions about students’ learning that was not evidenced in the medicine-specific literature: their learning how to work in a healthcare professional ecology (Abbott 1988) lead by medics. Hunter et al. (2008) describe a learning situation where a specialist trainee nurse is working ‘on’ a neonate with her preceptor. The medic who ‘issues the orders’ and ‘prescribes therapy’ has made a requirement that, to the preceptor, is troublesome not only because ‘the baby doesn’t seem to be tolerating’ the treatment, but also because the order ‘contradicts everything’ she has taught her student (p. 661). Hunter et al. report how the preceptor and preceptee make sense orally of their actions (which include not following the doctor’s instructions) while they stand over the incubator and perform the physical tasks of their profession on the baby inside. Similarly, in Dingwall’s study, HVs discuss with each other the disagreements they have had with medics about their patient interventions (1977b).
Relevant to the discussion here is the way staff manage potential inter-professional dissonance in profession-specific ways.

As described previously, neonatal nurses work in multidisciplinary teams, led by medics and all members of the team share computer-based records about each baby. In this environment Hunter et al. (2008) observed nurses performing consistent practices to resolve potential areas of conflict with the medical staff. Firstly the preceptor found a junior doctor who ‘agrees with me’ and, using this ‘path of least resistance’ wrote in the notes that a change in management had been ‘agreed’. Under the supervision of the preceptor, the learner was given the task of writing the change in the records. In her feedback to the student, the preceptor is recorded as commenting that the record ‘says what we’ve performed, it’s factual… and it describes how we negotiated it with x’ (p. 662).

Dingwall's work describes HVs managing potential conflict with medics in quite different ways. Dingwall (1977) suggests that the uni-professional working of HVs enables them to talk openly together about their work. As mentioned earlier, HVs have a strong oral tradition to the creation of their work, and Dingwall describes them dealing with doctor-generated professional disagreements through ‘a particularly dramatic part of the oral culture of the occupation’ - the creation of an ‘atrocity story’ (Dingwall 1977a, p. 394). Dingwall’s research is rich in examples of these stories that, in a few short statements, cast HVs and medics as interaction antagonists with the HVs ‘deriding the powerful’ (medicine) and ‘defending their own rational character’ (p. 375). Through shared atrocity story telling HVs are described as able to create an image of their profession that is both autonomous from, and at least equal in status to, their co-actor in the ‘story’.

Collectively the health-education research discussed here suggests that students observe and take part in profession-relevant interaction practices that, while claiming to protect the interests of patients or clients, actually protect the reputation of the individual professional and ‘secures social recognition (for the profession as a whole) by asserting claims to a certain relationship with other occupations’ (Dingwall 1977b, p. 161). By performing these ‘assertion’ strategies in front of students, and requiring their co-performance in some of their elements, work-placement educators ‘coach’ students to ‘produce’ the strategies independently. In so doing, and because these strategies, and other locally acquired and valued tacit professional knowledge, are neither noticed nor critiqued, the education system perpetuates inter-professional practices that, overtime, ‘become self-fulfilling’ (Dingwall 1977a, p. 385) in contexts where other resolutions may have been both possible and
desirable for the sake of the patient about whom the circus of healthcare professional work rotates.

**Section summary**

As may be apparent from my writing, the ideas arising from the review of the health-related practice education research discussed here, although invisible in these words to me before, resonated powerfully with my professional experiences as a physiotherapist. The research has challenged me to consider skills teaching as a façade for the socialisation of profession-specific and locally mandated practice assumptions and values. The studies have described professional work practices, performed with or in the presence of students as legitimate members of the professional group, as acts to ‘establish exclusive claims to a particular area of work’ for that profession (Dingwall 1977b, p. 161). The students’ desire to present themselves as part of the group [whether or not an outward showing of ‘strategic compliance’ for assessment purposes (Clouder 2003, p. 215)] effectively reduces their interaction agency and leads to the cross-generational promulgation of practices and the values that underpin them. One major learning point for me has thus been to question the impact of group membership and professionalism work management on the learning experienced by students on placements and the students’ interactions with patients. Patient-centred care is repeatedly claimed as the core of practice in clinical settings, but the research reviewed here suggests that, in the presence of a student, in all but ‘cold’ medical and some HV patient-interview settings, the dynamics of the triadic interactions between patient, qualified staff member and student prioritise two 1:1 interactions: the staff: student and staff: patient interactions, with the former taking precedence over the latter. Despite being the foundation upon which physiotherapy placement education has always been built, the literature discussed here makes me question whether teaching, learning and patient-centred therapeutic interactions co-exist in physiotherapy education settings. In the final section of this chapter I draw together the ideas arising from my journey in social learning based research and create the focus for the observation study that forms the rest of this thesis.

**2.5 From literature review to practice: arriving at a focus for my project**

This chapter has drawn the reader through the key themes, questions and reflections that have informed the focus of the research I conducted for my EdD project and report in this thesis. Written as a critical reflective journey in ‘noticing’, the chapter has charted the major shifts, broadening, and in some cases abandoning, of my previously held assumptions in at
least three core areas: human learning, interaction and movement for communication purposes. Specifically my reading has made visible, and then challenged, the implicit cognitive perspective of human learning that had underpinned my previous studies into physiotherapy student education, and my positivist, quantitative-based thinking about human movement as joint angles and muscle tone.

Despite uncomfortable periods of dissonance between the readings and my long-held professional practice frameworks, there was no turning back once I had ‘seen’ learning as a social endeavour practically accomplished through interactions between participants in their specific environment. Through the detailed written records of direct observation of interactions and, on occasion, the inclusion of video stills of the interactions being described, I literally came to see how the verbal and nonverbal features of interactions speak volumes about the work being done by the individual participants. Instead of trying to trace the physiotherapy curriculum from the professional body’s core framework into the placement context, the research reviewed in this chapter challenged me to ask how physiotherapy students attempt to do ‘being ordinary’ (Sacks 1984) and learn to ‘move, speak, use instruments and establish social relations’ (Gherardi 2006) in ways expected by the qualified members of the specific community of physiotherapists with whom they were placed. Gherardi’s so simply stated four features of placement learning capture the lens with which I approached my fieldwork. Echoing Lave and Wenger’s observation that ‘it is not that learning occurs but what learning occurs that is problematic’ (Lave and Wenger 1991, p. 14), my research lens swung away from a cognitive perspective of learning with its focus on explicit skills education to one interested in the socially generated and transmitted tacit values and assumptions that, like jelly, occupy the spaces and hold the interaction practices of placement educators and students together. This mapping out of what goes on in physiotherapy placement learning settings is my primary claim to the originality of this research.

In conclusion therefore my project follows the actors in the practice learning environment and emphasises the exploration of their observed interaction practices over their formal narrative accounts about that practice. Specifically I aim to map the ‘life as usual’ experiences of students on placement to illustrate with whom they interact, the features of these interactions and thus how physiotherapy placement education is done. If it is possible to suggest what the students are learning through these interactions I will do so, but this is not the main focus of the study. In simple terms I want not to judge practices, as I am in no position to do so, but rather to lay out and make visible for others the interaction practices I observe. My hope is that this mapping out of practices, if accessibly achieved, will enable
physiotherapists to reflect on the interactions thus exposed and consider the next steps in their professional project.

In the next chapter I discuss the methodological perspectives that informed the study and the method of data collection I created to achieve my study aims in ways that were methodologically robust and sensitive to the complexities of the interaction practices I observed in the field.
Chapter 3: Methodology.

3.1 Introduction

The literature discussed in Chapter 2 suggested that learning in work placement settings can be evidenced by learners' interaction practices as they perform the everyday activities of their specific work group in ways that increasingly enable them to become invisible in the web of practices enacted by the group’s long-established members. Two broad research questions originated from the review:

- How is physiotherapy placement education socially accomplished? and
- What is going on in student-present physiotherapy placement interactions?

This chapter evidences my critical engagement with a seam of literature discussing methodological perspectives and study approaches that were appropriate for my exploration of these research questions. By the end of the chapter readers will understand how my aim to make visible the minutiae of interactions-as-learning events led to the recording, processing and analysis of specific types of data in specific ways during periods of observation in the field. The decisions I made about the execution of my study were cognisant of related theoretical discourses and located in the context of the pragmatic concerns of my research timeline. In the course of the chapter I introduce readers to a new method of data collection I created specifically for this study.

3.2 Preliminary concerns: challenges of being a good witness

   i) The need to observe placement education in real settings

Harvey Sacks' paper *On doing ‘being ordinary’* (1984) was a major influence in shifting the emphasis of my fieldwork from periods of observation focused on the physical activities being taught to students, to observation focussed on the minutiae of human interaction. Sacks summarises my transition as a shift in not thinking ‘of “an ordinary person” as some person, but as somebody having as one’s job, as one’s constant preoccupation, doing “being ordinary”’ (1984, p. 414). From Sacks' perspective ‘pretty much everybody’ is working, ‘with every possible effort’, to find out ‘how it is that which is going on is usual' and then to take on themselves, as members of that specific interaction community, ‘the job of keeping everything utterly mundane’ (p. 419). Resonating with Lave and Wenger's (1991) ideas about legitimate peripheral participation in situated learning environments, Sacks suggests
that students need to have available opportunities to try out and practise their ‘doing “being ordinary”’ in specific interaction settings.

The first days of pre-registration physiotherapy work-based learning placements typically involve students shadowing or co-working with their educator as the latter completes their daily patient list. Through Sacks’ lens these early patient-contact interactions are crucial experiences to orientate students to the specific work-as-physiotherapy practised by the team with whom they are placed. An observation of students’ naturally-occurring everyday interactions during the early phase of a placement could illustrate their attempts at doing being ordinary in the context of the proficient work of ordinariness performed by their educators. While simply stated, observation in fieldwork settings was a new and terrifying research approach for me. The following subsections discuss sociology-based ideas about ‘observation’ and illustrate how they informed the approach I adopted in the field.

ii) Not any old observation but ‘empirical observation’

Dingwall writes that ‘if our objective is to understand the foundations of social order… observation must be the method of preference … (as it) shows us everyday life brought into being’ (1997, p. 61). Baszanger and Dodier use the term ‘empirical observation’ to describe an approach to fieldwork where the observer ‘rejects all a priori knowledge’ about the setting they are observing and remains ‘open in order to discover the elements making up the markers (the linguistic and paralinguistic resources) and tools that people mobilise in their interactions with others’ (1997, p. 9). This sense of detachment and deliberate setting aside of personal assumptions and expectations was helpfully illustrated by Goffman in his lecture notes about fieldwork. Goffman describes the researcher ‘physically and ecologically penetrate(ing)’ interaction participants’ ‘circle of response to their work situation … so that (the researcher) is close to them while they are responding to what life does to them’ (1989, p. 125). Resonating with Garfinkel’s challenge that researchers should make the practical everyday organisation and working of a group visible ‘as it is seen from within’ (1964, p. 249), Goffman describes his own field work experience as ‘artificially forcing yourself to be tuned into something that you then pick up as a witness… not as a listener but as a witness’ (1989, p. 126). The distinction between being a witness to, or a listener of, interaction events made an impact on my interpretation of research methodologies as discussed below.
iii) Research perspectives informing my practice as an interaction witness

A special edition of the journal *Discourse Processes* offered an 18-minute, observation-generated data extract (of a small-group based tutorial for undergraduate medical students) to five sociologists with each asked to write a paper about their interpretation of that data (Koschmann 1999). The electronic copy of the journal I accessed had the verbal elements of the interaction attached as an appendix to the editorial but was missing the video clips contained within an original CD-ROM. As a novice to interaction research, the papers illustrated the markedly different methodologies, or philosophical perspectives, underpinning the researchers’ ‘direction of their attentions … what constitutes the event’ and their subsequent processing and analysis of the data set (Koschmann 1999, p. 107). Indeed so alien to me were some of the researchers’ perspectives that I found their papers impenetrable. Hall’s analysis (1999), the final in the series, was different and is discussed below.

While never stating his underpinning perspective in so many words, Hall was clearly interested in the interactions between the students and the work being performed by the learning task to hand (Hall 1999). Like Lynch and Macbeth (1998) and Jensen et al (2005), Hall’s paper included video stills of the interaction. Through these photographs Hall illustrated how the physical actions that accompanied the students’ spoken words contributed to their discussion and building of a shared meaning about the learning task. Hall argued that the shared meaning of terms used by the group members could not be deduced from analysis of the verbal elements of the interaction alone.

This focus on the physical dimensions of an interaction goes beyond my discussions in Chapter 2 to note how the perspective of the researcher influences what he sees and considers recordable. Hall described the scene he was watching on the CD-ROM changing shape ‘as the video camera pans around the room’ (1999, p. 192) and thus how his experience of the observed interaction altered because of the choices of the camera operator. As the camera angle broadened so Hall became aware of previously invisible artefacts around the students for example ‘the whiteboard covered with writing, a table surface informally partitioned into local workspaces… a neuroanatomical flip chart showing a three-by-three array of brain sections’ (p. 192). Hall suggests that these ‘missing’ features from the earlier parts of the data set were important for his research questions and the analyses he wanted to conduct.
Similar challenges of operator selection and framing are reported in the video-ethnography literature (see for example Jordan and Henderson 1995; Pink 2007). While the ethical approval for my study prevented the use of video recording equipment in the field, the issues raised by Pink, and Jordan and Henderson, and illustrated in practice by Hall’s analysis, were relevant nonetheless for my observation study, and challenged me to consider explicitly the theoretical lens through which I approached all activities related to ‘data’. Silverman notes that as ‘no view of data is more real or more true than another’ (1998, p. 99), it is the researcher’s role to articulate how she conceptualises the world in the context of the work of other researchers and the influences of this positioning on the lens through which they collected relevant evidence as data. In the next section I walk the reader through a seam of the methodological literature to articulate the stance I adopted to the collection, processing and analysis of my fieldwork data.

3.3 The methodological approach to my study: does it have a label?

My physiotherapy-based experiences of making explicit my methodological stance and ‘positioning’ have always seemed fraught with expectations of exactness that challenged the reality of inquiry into student learning. In my doctoral reading I took heart from Silverman who argues that methodological perspectives should not be set up as ‘paradigmatic oppositions’ and defended like ‘rival armed camps’ (1998, p. 110). While I have certainly read sociology-based texts adopting rival positions, I aim here to steer clear of the ‘arcane’ (p. 717) and ‘hyperintellectualised debates’ (Lynch 2008, p. 715) that polarise discussions. Instead, and not as an opt-out but rather in the spirit of Silverman (1998), I illustrate how theoretical ideas about social interaction and learning introduced in Chapter 2, together with an exploration of the literature about interpretivist perspectives, led to my adoption of a methodology that resonated with Pollner and Emerson’s notion of ethnomethodologically informed ethnography (2001). In the following subsections I look separately at the ideas behind the terms ethnography and ethnomethodology and conclude with an articulation of my position within the current research.

i) Perspectives of ethnography

Atkinson and Pugsley describe ethnography as a ‘general approach to the exploration and understanding of social settings and social processes’ (2005, p. 228). While this definition could apply to a number of interpretivist-aligned approaches, Gubrium and Holstein (2000) suggest that ethnography’s distinct claim is to research questions framed in terms akin to ‘how do participants see things?’. Typically adopting an open-ended approach when
entering the field, ethnographers spend considerable time ‘immersed’ in the day-to-day lives of the social group being studied (Robson 2002, p. 187). Through extended and concurrent fieldwork practices of observation and talking with the group’s members, researchers come to a point where they can describe how the people in the study group view the situations they face (Hammersley and Atkinson 2007).

Atkinson (1992), Pope (2005) and Richardson (2006) provide personal, reflective accounts of the focus and work of ethnographers in UK healthcare settings. Their stories and examples of observation-stage field notes illustrate that the ‘data’ that forms the focus of an ethnographic analysis is not directly collected in real time in the field. Rather, the ‘very partial records’ (Atkinson 1992, p. 454), ‘embarrassingly scruffy’ jottings, ‘hasty sketches and idiosyncratic abbreviations and shorthand’ (Pope 2005, p. 1182), together with snippets of practice explanation commentary by the observees, form the basis of a careful data creation exercise conducted by the researcher away from the field. As Pope describes, ethnography ‘relies on the researcher to act as the research instrument’ and through their writing skills ‘transform’ (p. 1182) the array of field note records into ‘a rich, inclusive account of how workplace activities and practitioners’ views weave together’ (Richardson 2006, p. 81). These written accounts become the focus of analysis and suggest directions for further cycles of observation, interview and writing. Through a process of iterative enquiry ethnographers thus develop tentative theories, collect further data, create new accounts and remain ‘constantly on the lookout for omissions and conflicting ideas’ arising between their new field data and previously generated accounts (Richardson 2006, p. 85). The ethnographer’s aim is to work closely with the study group, to understand their behaviours ‘in their own terms’ (Atkinson and Pugsley 2005, p. 230) and, through the writing of accounts, convert members’ rules and norms into ‘inclusive causal explanations’ (Pollner and Emerson 2001, p. 126).

Critics of ethnography challenge what they describe as the ‘subjectivity’ of the ethnographer’s process of data collection / creation, but the researchers themselves defend the validity of their approach on the grounds of their commitment to anthropological strangeness and on-going reflexivity. Ethnographers enter a field of study with a specific setting aside of prior assumptions and expectations about the study group they may have gained from other sources. This ‘ethnographic estrangement’ is a central and fiercely defended tenet of ethnography (Atkinson 1995, p. 19). The only adjustment to the anthropological strangeness requirement is the recognition that, when ethnographers work with groups who have a specialist professional knowledge (for example medicine), it is helpful for the researcher to ‘attempt to acquire some degree of ‘insider’ knowledge… to
become something of a well-informed citizen’ (Atkinson 1995, p. 18). This process knowledge helps the ethnographer get a sense of the ‘what is happening here’ so that they can more easily discuss practices with informants in their own terms. Through their cyclical data creation approach and on-going reflexive practice ethnographers claim objectivity and study validity (Atkinson and Pugsley 2005).

This short synthesis of my interpretation of ethnographic principles and practices suggests a number of opportunities and challenges of adopting ‘pure’ ethnography as a lens for my study. I discuss these below in the context of my personal and pragmatic concerns.

ii) Ethnography as a possibility for my study

The NRES application process required the identification, negotiation and confirmation of access to specifically named NHS staff groups at an early stage in my project preparations. The ‘epistemological shift’ I described in Chapter 2 took place after access specifics had been agreed as three two-day periods of observation with each placement team at the beginning of students’ four-week placements, and a one hour interview slot with the lead placement educator (PEd) and observed student at the placement’s end. Further, my selection of the neurology (neuro) and musculoskeletal (MSk) placements in one hospital as the sites for my fieldwork had no foundation in ethnographic ideas. Instead the groups were selected as examples of ‘core’ physiotherapy undergraduate specialities that, drawing on my prior experience as a clinical and academic physiotherapist, appeared to ‘do’ placement education differently regardless of the specific site of the placement. In addition, as a former neuro specialist, I thought I could draw on my understanding of placement education in this speciality to throw MSk practices into relief.

The obvious challenges to the adoption of an ethnographic approach were thus time, immersion and the disconnection between periods of observation and interview which effectively prevented a valid exploration of the PEds’ or students’ accounts of the practices I had observed. Further, the positivist in me was anxious about my ability to construct narrative accounts generated from field notes.

Pollner and Emerson’s (2001) paper however suggested that I could turn some of these perceived personal and structural disadvantages into research advantages. Recognising that ethnography ‘relies on the unselfconscious appropriation of members’ practical sociological reasoning to describe and analyse practice’ (p. 126) and the arguably minimal literature that I could draw on to foreshadow my observations in the field, the authors discussed the
supplementation of an ethnographic perspective with ethnomethodological ideas. As I discuss in the next subsection, this running together of ethnography and ethnomethodology was not a convenient ‘fudge’ but rather a deliberate decision to maximise the output of the negotiated fieldwork access and create a map of ‘what goes on here’ for future physiotherapy ethnographic studies to take forward.

iii) Practical lessons in ethnomethodology

Ethnomethodology (EM) is a style of analysis that focusses attention on the social construction of everyday practices. With its epistemological roots grounded in phenomenology, EM’s concern is to explore the ‘what is going on here?’ of social interactions. Garfinkel, the sociologist who adopted the term ethnomethodology, built on the work of Schutz to make visible, as ‘artful accomplishments’, the mundane, taken-for-granted elements of social interactions (Garfinkel 1968). The gaze of EM is thus on the minutiae of social interactions.

Pollner and Emerson suggest that a distinctive feature of EM is its commitment to providing ‘real time’ descriptions of events and actions with ‘historicity’ the ‘crux of the matter’ (2001, p. 128). With its emphasis on exploring ‘people’s everyday methods for producing social order’ (Lynch 1996, p. 265), researchers adopting EM perspectives focus on ‘an observable activity and its sequential arrangement’ (Atkinson 1988, p. 445) to get at the ‘quiddity’ or ‘the ‘just this’ of the here and now’ being observed (Pollner 2012, p. 13). EM also recognises that ‘social actions are… part and parcel of the context at hand’ (Heath 1997, p. 186) and that data collection must be rich in both context and practice descriptions. EM thus uses real time data to ‘catch at the nature of social action in the full flow of its movements’ and then interrogates these data to ‘examine the proprieties of its constituent moving elements’ (Heritage 1984, p. 74). A major and recurrent edict throughout the EM literature is for researchers to abstain from all judgments of the practices they observe in the data that might lead them to ‘argue with the members’ by superimposing uninvited and unwarranted interpretations on the members’ data (Pollner 2012, p. 13). For EM therefore everything one needs to know about what is going on in a setting is visible within the data collected within that setting (Randall et al. 2007). A central concern of EM is thus what constitutes valuable data.

To prepare for my fieldwork I watched publically available video recordings of physiotherapy practice and explored ideas about data in social interactions relevant to the physiotherapy placement education context. As discussed in detail elsewhere (Kell 2011), and illustrated in
Figure 3.1, the work of physiotherapy typically involves direct physical contact between a therapist and her patient.

Figure 3.1: The typical work of a neuro physiotherapist. The video still presents a ‘leg’ being stretched by a qualified therapist (in white), while her assistant restrains the opposite leg.  

![Image of physiotherapy interaction]

I thank the Spinal Injuries Association for permission to use this video still.

Figure 3.1 suggests that touch and the movement of the patient's body are important elements of physiotherapeutic interactions. Listening to the sound of video recording suggested that adopting a Conversation Analysis stance and focussing only on the verbal elements of the interaction would dramatically narrow the lens of my study. While exploring how students learn to do the talk (and silences) of physiotherapy is an expected aspect of their placement learning, the interplay between the talk, touch and spatial elements of their interaction performances and those of their PEds and patients, would I felt, provide a more complete picture of the practical accomplishment of physiotherapy placement education.

Lynch and Macbeth (1998), Heath (1997) and Heritage (1984) each illustrate the wealth of rich descriptions about social interactions that are available to EM researchers when an eclectic approach to data is adopted. From their perspective the conversational elements of interactions comprise both verbal components and the participants’ related nonverbal actions. Thus data includes the performance of illustrative gestures and the participants’ use of the interaction space, eye contact and artefacts dependent on the context. Typically this

---

6 I thank the Spinal Injuries Association for permission to use this video still.
data is collected both as field note observations and as electronic recordings to facilitate detailed analysis away from the field.

Surprisingly, given my inability to use electronic recording equipment in the field, I felt at home with EM ideas. While I felt the burden of the need to collect rich data in real time very acutely, I remember being more excited than overwhelmed by the possibilities EM offered. This aura of confidence arose from what EM researchers describe as my ‘unique adequacy’ in the culture of practices I was planning to observe. Unlike ethnography and early versions of EM whose researchers view prior exposure to the research community as detrimental to the study of social interaction, more recent EM perspectives (EM2, see for example Pollner 2012) actively encourage researchers to ‘make the strange familiar by becoming an adept practitioner’ (p. 11). Resonating with Goodwin’s notion of professional vision (1994), unique adequacy is seen as an asset in contexts where the ways and workings of a specialist group are only accessible through a competent practitioner’s in-depth experience and familiarity (Pollner 2012).

Thus, while I was not competent to practise in either neuro or MSk settings, my training and time as a lecturer made the major elements and sequences of physiotherapeutic routines recognisable. Familiarity with the broad patterns of physiotherapy work would also help me pick out where to look, and what to notice as the focus of data collection, from the plethora of background noise that bombards healthcare settings (Hindmarsh and Pilnick 2007). And finally, while I did not know at this point how to record the non-verbal components of interactions, my ability to notice muscle tweaks, use of space etc. were core to my work as a neuro therapist and would be an invaluable asset in the field. Adopting EM perspectives about field work data thus seemed sensible in order to ‘buttress and deepen’ an ethnographic approach to my study (Pollner and Emerson 2001, p. 118).

iv) Towards a label for my approach

This section has illustrated my engagement with the academic discourses of ethnography and EM, and charted the path to my adoption of a research approach and data focus appropriate for the research questions, my personal experience and the context within which I would be conducting field work. Livingston described EM as ‘the tinkerers’ craft’ (2006, p. 405) and this resonated with my experience as a neuro physio, learner, and everyday interaction participant who relishes tinkering through and around ideas and problems. By adopting an EM informed ethnographic approach I positioned myself to maximise my time in the field through the collection of data that focused on the ‘micro’ of social interactions and
buttressed the creation of written accounts which would form the dissemination of my research analysis. This dissemination activity is akin to, but in lieu of, participant validation of the accounts in the field (Bloor 1978) and recognises my responsibility to make my data available and accessible to my professional colleagues so that they can ‘reflect on their routine taken-for-granted practice and its impact on both patient and fellow practitioners’ (Dowling 2007, p. 830). With perspectives becoming clearer, Goffman (1989) and Dowling (2007) challenged me to refocus the emphasis of my concerns away from theoretical discussion and towards the practices of the communities whose everyday activities I was going to observe.

3.4 Preparations for my fieldwork

Goffman (1989) identifies two ‘problems’ that must be addressed during preparations for observation fieldwork: the ‘getting into place’ and then ‘the exploitation of that place’ (p. 126). In this section I discuss briefly my interpretations of these issues and how they were accounted for in my preparations. The discussions within each subsection are framed around the elements of preparatory ethnographic fieldwork described by Hammersley and Atkinson (2007).

i) Getting into place: where and how

Gaining access to Physiotherapy placement education sites and their incumbent educators and students was complex and two-pronged. Two-pronged because access was needed to University undergraduates and NHS sites and staff, and complex because each site had different access processes. This subsection outlines the access negotiation strategies for each site.

a. The University students

The challenge of two distinct prongs of access negotiations was that, with the NHS Research Ethics Committee (REC) processes so protracted, a long fieldwork lead-in was essential to ensure that successful NHS access was achieved in time to approach specific students on the named placements that had received the REC consent. If these students then refused to take part in the study I had major problems. To reduce the possibility of this outcome I worked closely with the Academic School, achieved their REC approval, and kept the local gatekeepers (Programme Leader and Placement Coordinator) briefed about the
project’s extent and scope. Specific issues arising from the access negotiations are discussed below.

Each placement provided by the University I wanted to access was summatively assessed by the placement educators. Marks from the eight pre-registration placements accounted for 28% of the students’ final degree classification. University-based access negotiations thus explored the potential impact of my presence on students’ learning and performance. University access to its students was granted for two days of observation during the first half of the four-week neuro and MSk placements during their fifth, sixth and seventh placement periods. These placement choices reflected the academic team’s experience that my early presence would be unlikely to impact on summative placement scores, and that students who had completed four previous placements would be confident in the general practices and expectations of placement learning and thus unlikely to be unduly disturbed by my presence in the field.

When NHS REC and School approvals were achieved the School released the names of the students listed to attend the approved placements. With the help of the Placement Coordinator I conducted face-to-face discussions with the students to set out my plans, answer their concerns and gain their consent to take part in the study. Hammersley and Atkinson (2007) suggest that researchers plan for access meetings by thinking through how much about their study they need or are willing to be open about with potential participants. My commitment to EM informed ethnography with post-study dissemination enabled me to be frank about the focus of my observation and what I would be doing with the data. Students were reassured that their involvement with the study would stop once their placement was over, and that I was just making visible what went on and not judging their performance (or that of their PEd). All students approached agreed to my observation of their placement education interactions.

b. The NHS placement sites

As Neurology and Musculoskeletal (MSk) physiotherapy placements are offered in both hospital and community settings country-wide, I needed to decide where to conduct my fieldwork observations. Pope (2005) suggests that practical, personal and pragmatic influences impact on study location choice just as much as theoretical considerations, and these certainly influenced my approach to a hospital site with which I had gained familiarity over my years as a clinician and academic. While I had no recent experience of clinical practices at the site, I knew the physical layout of the work areas and anticipated that this
spatial familiarity would enable me to orientate quickly in the field and thus focus on the interaction practices being played out.

A potential challenge with this site choice was my familiarity with physiotherapy staff who had been former colleagues and / or students. Richardson (2006) suggests that familiarity can be a double-edged sword as each party assumes certain roles and fieldwork behaviours based on previous experiences. In this instance former colleagues were the gatekeepers to the NHS sites I wanted to access. Following discussions with my supervisors, I considered my familiarity to be an asset to site access and approached the most senior therapist to gain access approval in principle before commencing the NHS REC procedure. As a non-NHS employee I needed an Honorary Contract with the specific NHS Trust in order to enter and conduct research on their premises and with their staff. Senior therapists sponsored my application, acted as named contacts for their staff during my study and also opened access negotiations, on my behalf, with their colleagues likely to be observed during my fieldwork in their role as educators. I experienced only interest and welcome from the senior therapy teams and thank them wholeheartedly for their support.

My concerns about the impact of my observation on other former colleagues and students also proved unfounded as only one neuro PEd observed in the field was known to me. While unfamiliarity with the majority of participants ameliorated some anxiety about observer influences on therapists' daily practices (Atkinson and Pugsley 2005), complete unfamiliarity itself can be troublesome (Pope 2005). I thus used the pre-fieldwork discussions to both build rapport with study participants and to confirm my lack of currency in the specifics of therapeutic practices in both placement locations and reduce staff anxieties about an implicit practice audit agenda. Collectively these preparatory activities were invaluable and raised multiple issues about fieldwork in hospital settings that were invisible in real, practical terms in the literature I had read. Here I discuss specifically issues of consent and impression management.

The place of the patient in the observation and processes for achieving their informed consent for study participation exercised much discussion at my NHS REC interview and was a major challenge that required the support and access-by-association of the lead PEds in each clinical setting. In the MSk site, the departmental administrator organised patient appointments in the students' diaries well in advance of their placement. With her support each patient likely to be seen by the student I was observing received an information sheet and consent form with their appointment. When the patient arrived for their therapy the student went alone to meet them in the waiting area to receive or complete the consent form.
Achieving patient-by-patient consent at the neuro site was not always possible because the nature of some patients’ conditions challenged their potential to give informed consent. The lead neuro PEd felt that limiting students’ placement experiences to ‘consentable’ patients on the days of my study was unhelpful both to the students’ learning and the PEd’s caseload management. Using the PEd’s initial contacts I thus conducted a series of access negotiations with the Nursing Managers on the wards whose patients the students might be treating. After their discussion with their nursing and medical colleagues it was agreed that, in the best case, patients should give direct consent to a request made by the PEd, if this was impossible and a relative was visiting (a common occurrence) then they could be asked to provide consent, and finally, if neither of the above applied the medical staff gave blanket access consent. A series of staff, patient and relative study information and consent forms were thus created and approved by NHS REC.

The success of my study is thus due, in no small measure, to the help I received from every level of the physiotherapy hierarchy and senior healthcare team staff at the study site. Pope (2005) advises researchers to consider ‘the impact of routes into the organisation’ on the way they were subsequently received and positioned within the power dynamics of the local cultural group as they went about their fieldwork (p. 1182). My route into the organisation used a top-down approach appropriate for the hierarchical workings of the NHS, and the support of former colleagues during access discussions confirmed my standing as ‘alright’ to be present in potentially sensitive, dually clinical and educational interactions. It would be wrong however to suggest that the success of my access strategy rested on the order of my interviews and my preparation for them. If my literature review had taught me anything it was the power of the visual, nonverbal communicative elements of interactions on their flow and outcome. Explicitly adopting Goffman’s ideas about impression management (1969), I gave careful thought to my outward appearance and body movements during first meetings. Thus, when meeting PEds and Nursing Managers, I deliberately ‘changed into a costume which the natives would accept as a reasonable thing’ (Goffman 1989, p. 128) i.e. an adaptation of a physio uniform: navy trousers, a dark top and ‘sensible shoes’, while taking notes in a small notebook placed on a clipboard. Together with the verbal elements of my interactions I aimed to create the expected outward signs of my trustworthiness, competence, unclutteredness and thus potential to fit in (or become invisible) in the field.

With field access secure I felt the responsibility to collect meaningful data even more acutely. In the summer before my fieldwork I turned my full attention to performances of human interaction and both honed my ‘noticing’ skills and designed and practised a new data collection method as I describe below.
c. From noticing to recording real time physiotherapy interactions

The discussions in this chapter have set out my intention to record, in real time and with paper and pencil only, details of the multi-modal performance of physiotherapy student placement interactions. While the social interaction literature provided some practical advice on data collection in the field, I was concerned that I did not have the language skills to describe what I was seeing in words. I revisited the literature to explore other methods as discussed below.

Immediately applicable to my preparations were Jordan and Henderson's (1995) concerns about the positioning of the researcher (both physically and theoretically) within the viewable field of the interaction. Resonating Berger’s (1972) observation that by putting pen to paper I would be making a ‘minimal representation (of the original scene)... detached from the place and time in which it first made its appearance’ (p. 10), Jordan and Henderson advise researchers to consider, and then make explicit, what they have recorded and what elements of the interaction space they have ‘erased’. Through the frequent observation of physiotherapy videos I honed my ‘noticing’ skills and identified consistent features of the interactions. Specifically interactions appeared to involve participants’ use of physical space, talk, artefacts, touch-based direct body-to-body physical contact, eye contact, and movement. A paper discussing the choices and strategies for recording each of these elements has been published elsewhere (Kell 2011). For practical and word length purposes here I only outline the key elements of the method I adopted in the field.

- **Focussing the data collection:**
  I trained myself to stand motionless for the first few moments of each new interaction and, drawing on my rehearsed insider knowledge, got ‘a hunch’ about what I thought was going on. Then, noting the time, I began recording as rigorously and densely as possible. Whether I used one or multiple modes of data recording depended on my initial hunch.

- **Recording participants’ indexical rather than grammatically accurate talk:**
  West’s (1996) instructions to harness the urge to autocorrect participants’ interaction talk was surprisingly hard to achieve and required careful practice. In the field I recorded as much real, full text conversation as I could. By writing at speed I attempted to act as a human tape recorder to record verbal sequences that were free from ‘normalisation’ (p. 335). Overlapping speech and differences in the rate of speech were difficult to accurately record. Concurrent talk was an infrequent occurrence recorded by staggering speech text across
and down the pages of my field note book. Changes in speech speed were noted using dots (.) to indicate pace slowing or words to describe a quickening.

- **Proxemics: recording the use of, and movement through, interaction space:**

  Proxemics is the study of the use of space during interaction (Burgoon and Saine 1978) and describes body movement in terms of ‘movement flow’ rather than anatomical positions (Farnell 1994). Flow is influenced as much by personal confidence to move in that space (or ‘Umwelt’ after Goffman 1972) as by physiological body function. Farnell discusses the challenges of being a researcher of movement in a society with word and not ‘movement literacy’ (p. 937) and uses computer-based pattern-generation to decode video recordings of movement sequences. Before the widespread use of computers however, there had been attempts, especially in the field of dance choreography, to create a hand drawn movement-based notation system. The work of Laban (Laban and Ullman 1984) and the later adaptations to his work by Bartenieff (Hackney 2002), were major influences on my development of a stick figure sketching system to represent, in a static medium, the movement-based elements of interactions. Figures 3.2a and 3.2b are examples of sketches drawn in real time in the field.

  Figure 3.2: Examples of field-drawn proxemics sketches

  ![Figure 3.2a A pelvis supported leg raise performed by a student](image)
  ![Figure 3.2b A pelvis supported leg raise performed by an MSk expert](image)

  The proxemics sketches above record the same skill being performed on the same person (here a fellow therapist during an in-house skills practice session) by a student (Figure 3.2a) and the expert leading the session (Figure 3.2b). The sketches have been drawn following a specific protocol that orientates the ‘patient’ first and then draws in the therapist from the point of physical contact outwards. Particularly important to record accurately is a sense of the participants’ stability and movement flow as a feature of the relative position of their individual limbs and overall centre of gravity in relation to their base of support. These ideas
are embedded within the physiotherapy-specific movement discourses. While physiotherapists do not, to my knowledge, draw such sketches, students are taught to visualise these ideas in their heads (Rose 1999) and translate their interpretations of the 'normality' of the observed movements into written form for patients' records. The sketch in Figure 3.2a makes visible the mechanical inefficiency of the student's performance and the strain being placed on her back. Interpreting the sketch using Laban Bartenieff ideas also suggests the student's lack of movement freedom in space. While further interpretation of the sketches requires their integration into longer multi-modal data sequences about interaction, the figures introduce the potential of the pencil-based method to record interaction participants' physical orientation and their use of movement within the space. A similar sketching system was used to record communicative gestures, the use of artefacts and multi-participant interactions.

- **Kinesics: tracking the focus of participants’ gaze and recording paralanguage:** Kinesics refers to the nonverbal movement related elements of communication (eye movements, gestures, the use of silence and 'untalk') in the creation and sustaining of social interactions. Birdwhistell (1970) explored the use of facial and eye movements and related 'untalk' (grunts for example) within social groups and illustrated how participants learnt the ‘rules' of an interaction from the kinesics performance of others in a mutual 'cross-referencing (of) signals' (p. 201). Birdwhistell suggested that cross-referencing is most effective in settings where members are socialised to emit and recognise group-specific signals. Heath and colleagues have used Birdwhistell’s ideas to study a diverse range of social group specific interactions (for example Heath 1986; Heath and Luff 2012) and their work was particularly influential in my decisions about how to record interaction kinesics in real time.

Observing only the eye-movement-based features of my sample videos, it became clear that interaction participants were doing two forms of eye work: sustained gaze (usually performed by the therapist when in silent, direct physical contact with her patient as illustrated in Figure 3.1) and shifting, giving-and-receiving eye movements (usually performed during interview-based segments). Figure 3.2b illustrates how I recorded gaze using hashed lines that tracked its direction. Capturing cross-referencing signals in real time proved more problematic and resulted in my development of what I call a ‘kinesics stave’. As discussed elsewhere, I drew on Heath’s transcription system for recording eye-based paralanguage in doctor: patient interactions (Kell 2011). Figure 3.3 provides an example of a stave drawn in the field. The stave is created by writing snippets of participants’ matched verbal / silent
interaction components and their concurrent eye work one above the other. The kinesics stave is completed by writing, as in music, across the page.

Figure 3.3: A sample kinesics stave collected during the interview phase of a new patient (pt) MSk assessment.

The extract in Figure 3.3 illustrates the principles of creating a kinesics stave and suggests that participants’ mutual recognition of, and responses to, cross-referencing signals keep the patient quiet while the therapist writes notes, and verbally active in response to a question from the therapist accompanied by an eye flash to the patient’s face. Kinesics staves were only recordable where there was no physical contact between patient and therapist. As soon as contact was made gaze became a more important device to direct the interaction.

This section has discussed the preparatory work that enabled me to maximise the potential of my time in the field. The new method required practice and trials of pencils and weights of paper to enable silent, speedy but accurate creation of data. Armed with a ‘uniform’ and an array of consent forms, propelling pencils with integral erasers, clipboard, notebooks, and a washable shoulder bag to carry my field kit in, I entered the field.

3.5 Practices in the field

Earlier sections of this chapter have orientated readers to the focus and details of my fieldwork. Here I discuss my place as an observer within the field and illustrate how my commitment to reflexivity informed the validity of the real-time interaction data I collected.

i) My position in the observed interactions

Field relations, the relationship between and mutual role expectations of fieldworker and observed group members, are central to the type of data generated in the field (Hammersley and Atkinson 2007). In order to collect detailed, real-time field notes I negotiated access that placed me in the role of ‘participant observer’ such that participation was not therapeutic but recognised, and made available for reflection (Pope 2005), the impact of an ‘other’ (me) in
the interaction space. Participant access also enabled me to conduct snippets of ad hoc conversation with therapists and students to explore some immediately important ‘what is going on here?’ questions.

My ‘participating-only-as-a-silent-other’ role worked well in general but was amended in two specific cases. The first amendment was made consciously and following in-the-field reflection on my rapport-building (cross-referencing) with the neuro ward staff. As we will see in Chapter 4, neuro physiotherapists treat patients in their bed area and certain environmental preparations are needed to make this happen. In what I later describe as the ‘bed dance’, there was a visible pattern to the space entry and leaving sequences which included the movement of curtains and tables. Calculating that my moving tables and curtains did not constitute a breach of professional conduct, I responded to the quick-flick eye cues (my face-curtains-patient) from the PEd and helped the student ‘sort’ the space while the PEd prepared the patient. The receipt of a small smile suggested that this was an appropriate ‘participant’ activity to perform.

The second adjustment occurred completely subconsciously three times. In each case students were alone with their patient with me observing as normal. Suddenly I perceived, in the instant that the students amended the planned activity they were performing with the patient, that the patient was at risk. Each intervention involved my taking a step forward towards the student and patient. The movement was noticed / sensed immediately and students stopped their activity before flashing me a quick smile. This intervention reflects my unique adequacy observing physiotherapy interactions and my ability to both read patients’ faces and predict soft tissue damage better than the student, but it is problematic from an ethnographic research perspective and required specific reflection. I acknowledge my intervention openly and recognise that in each case there was an explicit tension between my roles as an observer and a physiotherapist. Each intervention diverted the interaction from a path that might have thrown up interesting observation data (akin to Garfinkel’s disruption ideas perhaps), but I acted instinctively, as a therapist, to prevent patient harm.

ii) Reflexivity and maximising my data collection validity

Reflexivity, the dual acknowledgment that firstly what the researcher sees, considers recordable and the means by which they record what they observe in the field are shaped by their prior experiences, values and expectations (Hammersley and Atkinson 2007), and secondly that in the creation of these records the researcher is making a statement about what constitutes reality in the observed field (Garfinkel 1967), was an underpinning concern.
in the field and during every element of my working with the data in this thesis. The examples of my participant observer roles described in the previous section illustrate an element of my reflexivity informing researcher practices in the field. As a former physiotherapist I maintained an on-going state of alertness to my observation focus and data recording practices in order to balance my attentions on those aspects of the interactions that were of interest because of my professional competence as a therapist, and those that reflected an evolving competence as a social researcher. In earlier sections of this chapter I described how the balance was achieved conceptually by constantly relocating my professional vision (Goodwin 1994) and ‘unique adequacy’ type familiarity (Lynch 1993, p.274) / ‘ignoramus’ type strangeness (Atkinson 1995, p.19) by regarding the interactions as primarily forms of communication rather than ‘therapy’.

In the field these concerns translated into research practices that saw the detailed and rapid creation of notes only after a brief period of still observation. Prior to each period of intense recording I consciously balanced my physiotherapy and researcher lenses and, establishing a preliminary sense of the ‘what is going on here’, began making a record of the interaction using whichever element of the method that seemed central to the accomplishment of the unfolding interaction. Further, I positioned myself wherever possible at ninety degrees to interaction participants to record proxemics sketches, hear snippets of conversation, and avoid being in the eye-line of any participant. By being really still, other than writing, I became invisible to the participants as they performed their work in everyday ordinary ways (Atkinson and Pugsley 2005). Recording these ‘ordinary ways’ required the use of all elements of my method in most interactions. After each day in the field I reflected on my record-making. Additional features of the data collection arising as a result of this reflection included the recording of time and talk sequencing when I was too far away from the interaction participants to record dialogue specifics, but close enough to record talk-initiation and turn-taking sequences. Collectively this attention to the reflexivity requirements has resulted in interaction transcripts that give readers ‘access to the rich immediacy of the lived order’ of my observations (Pollner 2012, p. 13). Appendix 1 provides the full transcript of one interaction for illustration and will be discussed in detail in Chapter 4.

Finally, in order to explore the validity of my method I have presented elements of the data at conferences. At one event a non-physiotherapy attendee exclaimed ‘That is so physio!’ in response to my slides. This and other comments from medical staff, former patients and their carers suggest that there is sufficient validity to my data to warrant closer analysis of what they record as going on in physiotherapy student placement interactions. I turn to a discussion of my data processing methods and analytic approach in the next section.
3.6 Doing the data justice and not arguing with the members

Atkinson describes as ‘dazzlingly large’ (1992, p. 452) the variety of ways that field data can be organised and the range of perspectives and ‘stories’ that become visible (or are silenced) by researchers’ data processing choices. Figure 3.4 offers a schematic representation of my data exploration journey and records the key reflexive learning and / or noticing moments that enabled me to both set aside my assumptions about the interaction practices I observed, and see the consistency of those practices more clearly.

Figure 3.4: Schematizing my analytical process to capture both the sequencing of the processing activities and the shifts in my analytical lenses and perspectives.

<table>
<thead>
<tr>
<th>Analytical process</th>
<th>Main output</th>
<th>Questions arising / shifts in perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mapping the data sets into themes and instances.</td>
<td>Large, colour coded and dataset indexed mindmaps.</td>
<td>How can I support this theming within the data? How are participants’ practices evidencing my themes?</td>
</tr>
<tr>
<td>2. Learning to write: collating and narrating each participant’s practices in the neuro dataset.</td>
<td>Thick descriptions of participants’ practices. Beginning to unravel the blur of practices which dominated my perception of neuro practices (see Appendix 2).</td>
<td>Tracking individuals’ practices suggested that patient-facing interactions followed a broad pattern.</td>
</tr>
<tr>
<td>3. Writing up and running whole patient-facing interaction sequences.</td>
<td>Emergence of sequencing patterns (see for example Appendix 1 and Table 6.14).</td>
<td>Revisit neuro dataset to explore how student-present patient-facing interactions are practically accomplished.</td>
</tr>
<tr>
<td>4. Creating a thick description of the day-in-the-life of a neuro placement student.</td>
<td>Chapter 4</td>
<td></td>
</tr>
<tr>
<td>5. Repeating the thick descriptions for the MSk dataset.</td>
<td>Chapter 5</td>
<td>Recognising practices and critiquing their resonance with related social interaction literatures.</td>
</tr>
<tr>
<td>6. Revisiting whole datasets for cross-cutting themes.</td>
<td>Chapter 6</td>
<td>Making visible the practices which, while different in some ways because of the contexts of their practice, in other ways perform similar work in the conduct of patient-facing interactions.</td>
</tr>
<tr>
<td>7. Sense-making of results and relevance to physiotherapy placement education specifically, and work-based learning more broadly.</td>
<td>Chapter 7</td>
<td></td>
</tr>
</tbody>
</table>
Perhaps reflecting my familiarity with quantitative research methods, my first instinct (Figure 3.4 Point 1) was to inspect the data ‘for categories and instances’ that, by a process of ‘physical fragmentation’ disaggregated the data to illustrate practice patterns and outliers (Atkinson 1992, p. 455). This coding activity took many months and resulted in a series of large sheets collating, through the use of colour and item codes, the presence or absence of practice themes across placement settings and interaction participants. A challenge from my supervisors to evidence the themes I had generated within the data was a major learning moment in understanding what the ethnography texts describe as the iterative process of moving from writing up the data, through a ‘general description of observed events and processes, towards developing and testing explanations or theories’ (Hammersley and Atkinson 2007, p. 160).

As illustrated in Figure 3.4, reviewing ethnographic and ethnomethodological ideas about working with data suggested that, while my first data processing activity had orientated me to the data, I had imposed my own interpretation on members’ actions: I had fallen into the trap of ‘arguing with the members’ (Pollner 2012). Learning from Fielding and Fielding (1986) and Atkinson (1992), I returned to the data and used the ‘whole cloth’ to link related field note, proxemics and kinesics data and thus retain the richness of the data that I had painstaking built into the development of the data collection tools themselves (Pollner and Emerson 2001). Firstly I taught myself to write and, beginning with the neuro data, wrote long case studies, or thick descriptions, of each student and educator. By focussing on each participant’s broad daily activities and then the minutiae of their interaction practices (for example their postural features and associated space interaction practices), I began to notice practice consistencies and interaction sequencing among the seemingly disparate blur of neuro participants, work contexts and patient therapies. Once possible patterns emerged I went back to the full neuro dataset and, now keeping sequences of multi-form data together, recast the data processing along timelines (see for example Appendix 1 and the detailed neuro practice description in Chapter 4). The attention to long data sequences increased the authenticity of my outcomes by not placing ‘excessive significance’ on isolated segments of data that are impossible to revisit to verify (Fielding and Fielding 1986, p. 49) and enabled the neuro participants’ actions to speak for themselves.

Having undertaken the processing of the neuro data in this way, I was able to notice practice pattern similarities and differences within the MSk dataset and extend descriptions of the participants’ everyday practices to consider the resonances between the examples in my MSk dataset and those discussed in the related literatures exploring the accomplishment of social interactions. In Figure 3.4 I set out my shift in the analytical processing of the MSk
data and indicate how that process links to the structure of the remainder of this thesis. In
sum the next two chapters form the main results chapters of this thesis and set out the
typical everyday interaction practices of student-present placement education interactions at
each site. Chapter 4 (written first) makes visible a typical ‘day in the life of a student on a
neurology placement’ but offers no theoretical commentary about what might be going on
during the observed interactions. In contrast, Chapter 5 discusses the experience of the MSk
students and places observations in the context of social interaction discourses. Such
discussion prepared me (and will prepare the reader) for the analysis and synthesis chapter
through which I attempt to explore social action in terms of ‘hows’ and ‘whats’ (Gubrium and
Holstein 2000). In Chapter 6 I draw out and theme the enactment of locally performed
practical reasoning or the ‘hows’ by which members establish and sustain social regularities
in each placement area. I then test the application of each group’s interaction practices in
the context of the other group. Finally, recognising that these ‘hows’ are evidence of the
work social group members are doing to ‘do being ordinary’ while performing set tasks within
a set context (the institutional and cultural discourses for example) and with the physical
resources to hand, I consider the interplay between these ‘whats’ of social reality and the
‘hows’ by which everyday life is accomplished.

3.7 Chapter conclusion

This chapter has discussed the theoretical considerations and practical preparations that
enabled me to explore my research questions in the context of naturally occurring
physiotherapy placement education. The journey was theoretically and conceptually
challenging, occasionally bureaucratically numbing, but at all times focussed on the end
product and its potential value to my informants and the profession as a whole. The details
of the specific placements and study participants are included in the results chapters, to
which we now turn, in order to link context to data discussions explicitly. I begin with the
neurology placement in Chapter 4. While the reader may find elements of Chapter 4 naïve,
the text reflects where I was in my thinking about social interaction when I first wrote it, and
is thus an important record of my development.
Chapter 4: Experiencing a neuro placement.

4.1 Introduction

This chapter makes visible the typical first week experiences of third year physiotherapy students on a neurology placement. This chapter draws on detailed field work data and interview transcripts to illustrate the journey I have undertaken in noticing and understanding the practical accomplishment of placement learning with this team. The chapter begins by discussing the broad aims, plans and intentions for the placement as described by the University and the lead placement educators (PEds). Having placed the learning experiences in context, the majority of the chapter uses fieldwork data to describe the reality of naturally occurring placement learning interactions.

4.2 Setting the scene

I accompanied three third year students for two days during the first week of their four-week neurological placement. The placement was located in a large teaching hospital. The neurology service combined in-patient and outpatient provision to a range of people with differing health statuses and physical and cognitive impairments. The service was provided by the ‘neuro’ team which was subdivided into ward and outpatient based groups. Each group had a team lead therapist (Band 7\(^7\)) with the overall service managed by the Ward Lead. While the groups were distinct in most of their routine activities, the outpatient team joined the ward staff to support the in-patient service when the latter was placed under planned or unplanned case-load stress.

The in-patient caseload was spread over four half wards and supported patients with long-standing conditions during acute relapses, acute new cases of non-stroke related conditions and routine and emergency neurosurgical admissions. The ward-based physiotherapy team comprised five full time staff (one Band 7, one Band 6 and 3 Band 5s) who only saw patients referred to them from the ward doctors. Access to the outpatient team was via referral from medical staff in hospital clinics and GP practices, and from physiotherapists from other units. The outpatient team was made up of two part time Band 7s (totalling 1.2 full-time equivalents) and one Band 6\(^8\). Of the eight-strong team all except one of the Band 5s were female.

\(^7\) Please see http://www.nhsemployers.org/PayAndContracts/AendaForChange/NationalJobProfiles/Documents/Physiotherapy.pdf
\(^8\) Both Band 6 staff were on a Trust-wide specialist neuro rotation where they spent 7 months in neuro-related units across the Trust. Both staff had done at least one neuro rotation. My first day of observation was their fourth day in their current rotation.
4.3 The mechanics of the placement

The University, in partnership with representatives from the placement educator community, and within the framework provided by the National Curriculum Framework (CSP 2002), create a list of Intended Learning Outcomes (ILOs) that students should be able to achieve by the end of their four weeks on a placement. These ILOs are disseminated to PEds and students through the Programme and Placement Learning Handbooks. For each placement there are two sets of ILOs: generic ILOs to be achieved in all placements and those that are placement speciality-specific.

The neurological placement offered to the students at the study site used the breadth of the service’s provision and thus students worked, with different PEds, in both in- and out- patient neurological settings. Staff rotated the role of PEd in each placement with roles agreed a week in advance. Table 4.1 maps the PEds to the three students I observed for this study. The two PEds were responsible for co-managing the student placement and were expected to work together to undertake the following required elements:

- negotiating learning outcomes with students at the start of a placement;
- organising and coordinating daily placement activities;
- conducting the formal mid-placement formative assessment review;
- liaising with a University link tutor who visits once during the placement and
- conducting the end of placement summative assessment.

Table 4.1: The Students and their lead neuro PEds

<table>
<thead>
<tr>
<th>Student</th>
<th>Ward PEd</th>
<th>Outpatient PEd</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Verity</td>
<td>Amelia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Band 7 Team Leader)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Isobel</td>
<td>Lorna</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Rotating Band 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Stuart</td>
<td>Amelia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Band 7 Team Leader)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Students usually shadowed or co-worked with their lead PEd except when the PEd needed to perform non-student-present activities (e.g. teaching junior colleagues, attending a medical ward round etc.) or had a patient ‘not suitable’ for a student. In these situations the students were placed with other neuro colleagues. I thus observed Julie working with all three students, Lucy with both Verity and Isobel, and Isobel with a Band 5 colleague (Gareth).
4.4 The aims and focus of the placement

As described in Chapter 2, I interviewed, as a pair, the Ward and Outpatient Team Leaders (Amelia and Charlotte respectively) as part of my access negotiations. At interview I invited the PEds to talk about their aims for the placement, their understanding of the given ILOs and the ways these translated into the learning opportunities they offered the students. I hoped that the interview would enable me to identify the types of data I might need to record in my field notes. The interview extract in Figure 4.1 follows Amelia and Charlotte's discussion as they responded to my question.

Figure 4.1: The lead neuro PEds' perspectives of the Year 3 placements they offer

Amelia: 'I hope to get them interested as well (hm) kind of show them ... I think there's ...
neuro's one of the areas seems to be quite mystified in university and people come out and they are terrified before they've even done anything or seen a patient and they've just got this perception that it's .. that it's really difficult and I think it's trying to break down through that and educate students and how to assess patients in a logical way that, . and give them the confidence that they can do it .. cos we still get juniors coming through who are terrified and you know spend the first few weeks saying I don't .. I can't do neuro, I had a really bad placement and actually (hm) they're fine and they have got all the skills and (hm) abilities to do it (yes CK) but .. you know I'd hope we can give students the confidence to then go onto their junior rotations and not be terrified when they get there or if (yes) they're on a medical rotation to have a go at assessing (hm) a stroke patient (hm, hm) and not feel that they can't do it.

We..(sigh) I suppose we start by… letting them in gently (Charlotte yea) (CK yes) so we don't ... you never get a student on any placement just starting we just never let them go loose (yea) and assess a patient.. there's always a period of observation ... perhaps a teaching session to discuss the various assessment (yea) um points,'

Charlotte: 'I would say we also have a long observation period that quite a lot of the placement .. I mean it's most of the first week really isn't it. You might.. start getting your hands on but you certainly don't treat a patient on your own really in the first week do you?

(Amelia, no).'

Amelia: 'And then it's getting them to do part of the assessment with you there and giving them a bit of feedback and ... and then I suppose it's different.. my teaching style is to try and get them to have a go and I think it's by doing it that's how they get the confidence that they can do it and (hm) ... some students perhaps you can't do that with because they .. they need support but I think others they might look terrified and then they'll have a go and they'll come away feeling a little bit happier (CK yes) because they've done it and they've tried and ... they might not have looked at everything but we'll just tell them that's ok and well what's our plan for next time (CK yes) and we'll look at that. ... and I think with handling, what we try and get them the experience with is the experience with patients with low tone and patients with high tone (Charlotte yea) so they're learning to move limbs without causing any pain to the patient or learning what it feels like with the different tones (CK hm yes).'

Charlotte: 'i think... gosh ... do we.... I don't know ... necessarily sit down and teach them that.. I think we probably observe them first and then fine-tune them from how they are if you
The interview extract in Figure 4.1 illustrates two experienced PEds’ thoughts about the purpose and practice of the neuro placement they offered. In Lines 1-12 Amelia states, expands and repeats that, for her, a neuro placement (of any Level) is about building students’ confidence in their ability to draw on skills learnt in other specialities and apply them appropriately in her context. While Amelia and Charlotte use terms within the Programme Handbook’s ILOs and Assessment Proforma (e.g. assessment, handling, skills), it is noticeable that their agenda for the placement is conceived as a breadth of experiences rather than student achievement of outcomes. Throughout the rest of the extract (Lines 14-44) both educators discuss placement practices that are framed about learning through observation, co-working and limited access participation.

My field notes supplement this extract with annotations about the level of eye contact the pair gave me and the speed with which they both spoke. These features of the conversation, together with its fluidity, suggest that the PEds assumed that I shared an understanding of their conversation. At the time of the interview I felt confident that I did have a shared understanding and knew precisely what I was going to experience on my first day of field work. When I came away and looked at my transcript however, I saw that I had little idea what the current work practices to which they referred actually entailed. What were the students being asked to ‘have a go at’? what was being ‘fine-tuned’? and what were they having ‘a broad experience’ of?

In sum therefore I entered the field aware that I would be observing students who were learning by shadowing and co-working with their PEds and that, in some way, the work involved the handling and moving of patients’ bodies. I had also learnt that my insider knowledge was as much a hindrance as a boon to fieldwork. My efforts to challenge my assumptions and expectations are evidenced throughout the rest of this thesis.
4.5 Experiencing a neuro placement

The rest of this chapter makes visible, using data from field notes, interviews and proxemics sketches, the accomplishment of typical neurological physiotherapy placement education at this study site. On the days I observed there were no timetabled teaching sessions but rather the students took an active part in a ‘blur of practices’ that made up the daily work of their PEds. Appendix 2 illustrates the critically reflective process with which I engaged with my early field work data and tried to make sense of this ‘blur’. The work discussed in Appendix 2 was a core step in my noticing what was being performed in front of me and lays the foundation for the discussions here. The following key points are perhaps useful to draw forward before the main text progresses:

- Orientating to a ward environment: Despite the data in Appendix 2 being collected on her first day in a ward environment, the student, Verity appeared unperturbed by the noise, smells and plethora of healthcare professionals bustling around that were completely disorientating to me. Verity’s ability to perform unsupervised PEd-directed tasks in this environment suggested an element of familiarity between her immediate impression of the neuro ward and other ward-based learning environments experienced on earlier placements;

- Physical spaces, artefacts and roles: The field notes in Appendix 2 suggest that the two groups forming the neuro team (the outpatient and ward-based staff) wore different uniform, carried different equipment and experienced professional space differently. Specifically the ward team were nomadic, carrying small equipment in tunic pockets and occupied specific (and different) niches of ward nursing stations on the wards they visited. Further, while the outpatient team had responsibility for their own data management systems, the ward staff navigated and contributed to multi-professional systems and record-keeping;

- Balancing patient care and student education: Appendix 2 evidences the effect of a diarised patient appointment system (outpatients) and a daily-prioritised-case-load system (ward) on the sense of time and pace in the neuro placement. While the outpatient team could book space for student support into their diaries, the ward PEds set students specific non-patient-contact activities to perform while they worked through the patient list deemed ‘not suitable for the student’;

- Shared language and work frameworks: the extracts in Appendix 2 suggest Verity’s familiarity with her PEds’ turns of phrase that, on their own, make no sense at all. Thus through Amelia’s everyday use of language and Verity’s complete understanding of it (even on her first time in this work space), we get a sense that
physiotherapists describe their work here in terms of doing and seeing, and that what they do and see when with a patient is determined by their understanding of the medically framed diagnosis with which the patient presents;

- The place of the patient in teaching settings: A recurring theme throughout this thesis is the place of the patient in a student-present physiotherapy interaction. The foundations for this are visible in Figure 1 Appendix 2 where patients are discussed by the neuro team by condition and physiotherapy input rather than by name.

It took months of data processing to get to the point where I saw in Appendix 2 what was in plain view from Day 1 of my field work: instead of a diversity of unrelated practices, each player had illustrated the consistency underpinning each of the seemingly disparate activities I observed. Mini-characterisations of the scope and focus of the two neuro physiotherapy practice settings experienced by each student collate these observations at the end of Appendix 2. The rest of this chapter builds on the ideas raised here to describe the typical experiences and practices of students on placement with this team.

4.6 Typical learning opportunities on this neuro placement

As we saw in Figure 4.1, Amelia and Charlotte’s aim for student placements was to provide a breadth of ‘hands-on’ experience that enabled students to grow in confidence in their ability to ‘do’ physiotherapy with neurologically impaired people. As lead PEd Amelia translated the University-generated Module ILOs into weekly activities that could be catered for by PEds within their normal activities and provide students with opportunities to see their progress. Table 4.2 outlines the placement-specific objectives relevant to this study i.e. those for the first week of a four-week placement.

Table 4.2: Site-specific Week 1 placement objectives.

<table>
<thead>
<tr>
<th>Week 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Complete a subjective assessment and database using a variety of relevant sources;</td>
</tr>
<tr>
<td>- Observe an objective assessment;</td>
</tr>
<tr>
<td>- Observe and discuss relevant treatment options and techniques;</td>
</tr>
<tr>
<td>- Be familiar with common problem definitions;</td>
</tr>
<tr>
<td>- Show an awareness of the role of physiotherapy within the inpatient and outpatient setting;</td>
</tr>
<tr>
<td>- With guidance show an awareness of the need to evaluate treatment during and between sessions;</td>
</tr>
<tr>
<td>- Show an awareness of the relevance of home exercise programmes and discharge planning.</td>
</tr>
</tbody>
</table>
In Figure 4.1 the Team Leaders described two forms of learning experience they used to help students achieve the placement ILOs and their own weekly objectives:

a) Formal pre-, during- and / or post- patient contact activities set up with a specific education focus and
b) Informal opportunities for co-working with colleagues across the team as they treat patients who need support from several therapists simultaneously.

Table 4.3 uses these broad descriptors and the time recordings in my field notes to provide a rough calculation of the way the students' days were occupied in practice. By dividing their activities into those spent in contact with and away from patients, Table 4.3 suggests that all students, regardless of their PEds, spent more time (approximately 60% of their day) in non-contact than in patient-contact-based activities.

Table 4.3: How the students’ time was used early in a neuro placement. (Note: Full day including breaks = 8 hours)

<table>
<thead>
<tr>
<th>Broad Activity</th>
<th>Verity (2 days averaged)</th>
<th>Isobel (2 days averaged)</th>
<th>Stuart (2 days averaged)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient related / contact time e.g. therapeutic and non-therapeutic</td>
<td>Av = 2.9 hrs per day = c 4/5 pts each day</td>
<td>Av = 3 hrs per day = c 7 pts each day</td>
<td>Av = 3.15 hrs per day = c 8 pts each day</td>
</tr>
<tr>
<td>Non-contact time activities e.g. notes, teaching, lone prep, hygiene, team talk, breaks and walking time</td>
<td>Av = 3.9 hrs per day (incl breaks) * likely to be higher as not timed accurately</td>
<td>Av = 4.7 hrs/day (incl breaks)</td>
<td>Av = 4.95 hrs/day (incl breaks - more walking time)</td>
</tr>
</tbody>
</table>

Notwithstanding time for breaks, the data suggest that the periods of away-from-patient activity comprised time receiving teaching from their PEd about a patient case, time preparing for patients in the absence of their PEds, and time working alone but in the company of other therapists writing daily treatment records. Thus, while the data illustrate Amelia and Charlotte’s intended placement activities being carried out in practice, analysis suggests a third learning setting for students: performing administrative tasks in shared physiotherapy spaces. All three of these learning settings will be explored in later sections of this chapter as I discuss the thread of typical physiotherapy practice that runs through them.
4.7 Selecting the field extracts to present in this chapter

As described in Chapter 3, I collected together and processed the data for each student and PEd separately and in detail. Taking this approach enabled me to sense patterns in the work values and practices of neuro physiotherapy at this site. Creating mind maps of my emerging threads (see Figure 3.4 for an example) enabled me to return to the full data sets and revisit these as whole events (see Appendix 1 for an example of this running sequence analysis). Adopting this cyclical approach warded against unsubstantiated assumptions about the work being accomplished and helped me notice practice consistency and emerging work patterns.

Interrogating the field data as described made visible the student-present practice similarities and differences across the PEd team such that:

i) Typically when a physiotherapist saw a patient with a student, their interaction with the student followed the same broad pattern: pre-contact briefing, therapeutic contact, post-contact debriefing, note writing;

ii) While time and patient case load pressures might curtail a pre-contact briefing, the focus and structure of these was similar across all PEds in both ward and outpatient settings;

iii) In the first week of a placement all PEds in both neuro settings selected new patient assessments as the major focus for their work with students;

iv) The verbal dialogue that took place in a patient interaction differed depending upon the expertise of the therapist leading the interaction;

v) Experienced therapists in both settings engaged students in the same form of verbal dialogue in front of patients regardless of the patient's level of consciousness or cognition;

vi) Therapeutic sessions with patients, where students were essentially extra pairs of hands in a complex interaction between many therapists and one patient, followed typical, but different interaction sequences to those students experienced one-to-one with their PEd and a new patient.

In this chapter I focus specifically on student experiences where they worked in a 1:1 relationship with their PEd. My data reflect the emphasis on new patient assessment work in the early stages of a placement and so it is on the processes by which these assessments are typically accomplished that this chapter focusses. By the end of the chapter the reader will get a sense both of the diversity of humans and work settings within which a student learns, and of the core thread that is student-present physiotherapy as experienced within this specific team. With the exception of the data in the complete interaction sequence at
Appendix 1, I include relevant field note elements within the flow of the text rather than cross refer to more appendices. I hope this will help readers access the data more easily.

4.8 The practical accomplishment of neuro physiotherapy education

This section explores the typical practices of physiotherapists in the presence of students in four identifiable activities: pre-patient briefings, patient contact activity, post-patient debriefs, and note writing and patient related administration. I focus specifically on 1:1 PEd: student interactions.

i) Preparing to see a patient

Each patient-contact session was preceded by a PEd-led discussion with the student. Figure 4.3 extends the data extracts of pre-patient briefings presented in Appendix 2 Figure 1 Lines 1-47 and 50-129. Figure 4.3 re-joins the interaction participants after the PEds have questioned the students about the patients’ medical diagnosis. While the full text in Appendix 2 places the extracts in Figure 4.3 in context, the latter stand-alone adequately to illustrate the role of the briefing in preparing the student for the spectacle of physiotherapy that is to follow.

Figure 4.3: Field note extracts of typical pre-patient briefing sequences.

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30</td>
<td>Amelia and Verity discussing the ward patient</td>
</tr>
<tr>
<td>08:30</td>
<td>Amelia: ‘What would you do about assessment?’ Turns to face Verity.</td>
</tr>
<tr>
<td>08:30</td>
<td>Phone ringing. Amelia and Verity ignore. Lorna passes by, picks it up, NA comes to investigate, Lorna passes her the phone.</td>
</tr>
<tr>
<td>08:30</td>
<td>Verity replying to Amelia. Amelia nodding. Then still, waiting as Verity continues.</td>
</tr>
<tr>
<td>08:30</td>
<td>Amelia: ‘Are you happy to do the assessment?’</td>
</tr>
<tr>
<td>08:30</td>
<td>Verity clarifies: ‘It’s a lot about muscle strength?’</td>
</tr>
<tr>
<td>08:30</td>
<td>Amelia: ‘So would you like me to do and then you?’</td>
</tr>
<tr>
<td>08:30</td>
<td>Verity: ‘Well I would like to see one so I know…’</td>
</tr>
<tr>
<td>08:30</td>
<td>Pair walk down ward applying hand scrub as they go.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30</td>
<td>Lucy and Verity discussing a new patient in the outpatient setting</td>
</tr>
<tr>
<td>08:30</td>
<td>Lucy: ‘So with the subjective [phase of an assessment] ask ‘what’s your main problem’ and direct it as we went through yesterday. So if you are talking about pain?’</td>
</tr>
<tr>
<td>08:30</td>
<td>Verity: ‘Ask them what they mean as may not be what you mean.’</td>
</tr>
<tr>
<td>08:30</td>
<td>Pair discuss what questions to ask. Lucy talks about her experience elsewhere: ‘But here they don’t…’</td>
</tr>
</tbody>
</table>

63
Lucy: ‘So we have done the subjective now the objective [phase of the assessment]. What will we do?’

Silence

Lucy: ‘Going back to those outpatients experiences, what are you doing this for?’

Verity offers++

Lucy: ‘Again all those other things you said but it really depends on what you see. If she comes in and you see x then… As we said yesterday your objective starts as soon as she walks in. Have a piece of scrap paper and what I find helps is to just jot down a few headings as a patient can take you off and you might forgot things you meant to ask.’

Verity takes a piece of paper and starts to make notes;

Lucy gets up and starts making phone calls, doing admin at desk end of room.

9.05 am Verity from plinth end: ‘Lucy, would I use a goniometer?’ [long-armed protractor for measuring joint angles]

Lucy: ‘Ideally’… pause, direct eye contact with Verity, ‘I’ll find one.’

Verity: ‘It says in the notes that she has full range so it may be OK.’

Lucy: ‘I usually do a full, half, three quarter things for speed really. Unless it is her main problem. OK perhaps see how you go. You may not need to get it out to do angles.’

Verity: ‘I could palpate couldn’t I?’

Lucy: ‘Just see how things go – are you done?’

Verity: ‘One thing I was going to ask you was…’

Lucy: ‘Are you aware of any guidelines or standards?’

Verity pause: ‘Do you mean NICE guidelines?’

Lucy: ‘Yes, there are NICE guidelines’ (gives some docs to Verity) ‘Some of these other things may be interesting too. Here we go, have a flick through some of these, we have plenty of time.’

Figure 4.3a Lines 1-8 and Figure 4.3b Lines 9-26 illustrate how both educators draw the briefing to a close by focussing on the patient-contact interaction that is to follow. In both extracts the educators ask Verity what she ‘will do’ when she meets the patient. The turns of phrase suggest that Verity will lead the interactions and the assessment of both patients’ physical status. It is notable however (Figure 4.3a Lines 6-8 and Figure 4.3b Lines 9-11+24) that Verity appears to be less confident thinking about the physical tasks of a new patient assessment than the background theory. Figures 1 (Appendix 2) and 4.3 also suggest that the educators emphasise Verity’s theoretical underpinning and focus less on her practical carry-through of theory into practice. The data here reflect the typical balance of focus in pre-patient briefings.

Both extracts suggest a third function of the pre-patient debrief: to source information about the new patient. While both PEds help Verity think about patient-related data, they do so differently because of the differences in their work contexts. In Appendix 2 Figure 1 Line 65 Amelia asks Verity to ‘do a database for the new patient’. In a ward setting, where patients are referred to physiotherapy through the ward medics, therapists have access to information about the patient in the form of the medical and nursing notes and use these to
construct an outline of the patient they are about to see. Thus in Lines 125-128 Amelia is able to help Verity create quite a clear picture of the patient they have yet to meet by piecing together other health professionals’ written records.

In contrast Lucy, in the outpatient setting, can only provide Verity with the hand written short referral from the patient’s General Practitioner. In Figure 4.3b Lucy introduces the terms ‘subjective’ (Line 2) and ‘objective’ (Line 9) that Amelia does not use. In physiotherapy the subjective phase of an assessment is a dialogue-based interaction during which the therapist tries to elicit the history of the patient’s presenting condition. This verbal interaction seeks to glean from the patient information that ward therapists would get from the ward’s various written-record systems. Particularly telling in Figure 4.3b is Lucy’s advice to Verity in Lines 15-16 and Verity’s response which appears to be an unquestioning reaching for a notes sheet. Implicit in this short sequence is a shared understanding that, in this data-poor environment, the subjective assessment has a specific purpose and that Verity must gain the information that is important to the work of a physiotherapist and not be distracted by the patient taking the interaction in other directions.

Figure 4.4 below supports the suggestion that helping the students gather appropriate patient-related information is a major function of the pre-patient briefing. In Figure 4.4 Isobel is joining her outpatient-based PEd Julie for a new patient assessment. Unlike Verity in Appendix 2 Figure 1, Isobel had been working on the ward until 6 minutes before the assessment was due to start. The interaction sequence follows Isobel’s briefing before she is expected to lead the subjective phase of the assessment (an expectation agreed between Julie and Isobel at the team briefing earlier in the day).

**Figure 4.4: Focussing a pre-contact briefing on information gathering**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Day 4</td>
</tr>
<tr>
<td>2</td>
<td>2.24 pm on the ward</td>
</tr>
<tr>
<td>3</td>
<td>Isobel notices time, asks Lorna if she can leave</td>
</tr>
<tr>
<td>4</td>
<td>CK and Isobel leave Lorna to finish off with pt., wash hands and dash down stairs to outpt</td>
</tr>
<tr>
<td>5</td>
<td>office.</td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>2.30 pm Down in office. Reading pt’s referral note at desk end while Julie shows previous pt.</td>
</tr>
<tr>
<td>8</td>
<td>and relative her wedding photos;</td>
</tr>
<tr>
<td>9</td>
<td>CK kneels by Isobel looking at referral card and listens as Isobel verbally goes through what she may have to do.</td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>2.33 pm Julie’s patient leaves.</td>
</tr>
<tr>
<td>12</td>
<td>Julie to Isobel: ‘Are you OK to do the subjective? Do you want to write it in rough first?’</td>
</tr>
<tr>
<td>13</td>
<td>Julie starts talking to Isobel about subjective for next pt. Gets a clipboard and puts in rough paper. Jots down some key phases of the subjective as she speaks (very smiley) to Isobel.</td>
</tr>
</tbody>
</table>
The subjective phase of the assessment dominates the dialogue between Julie and Isobel in the short interaction in Figure 4.4. Perhaps sensing Isobel’s anxiety and lack of preparation, Julie suggests (Lines 13-17) that Isobel does not write her notes from the patient’s responses to her questions into the treatment card direct but rather, following Julie’s guidance, makes notes that will be written up when the patient has gone. Given that Julie and Isobel have not worked together before this sequence, it is notable that, in Lines 16 and 17, Isobel seems to follow both Julie’s verbal comments and the written translation of those comments into acronyms on the crib sheet. The short sequence makes visible an assumed shared language and understanding of practice between Julie and Isobel.

Collectively the data in Figures 4.2-4.4 suggest that, when time permits, the pre-briefing phase of a patient interaction is used to help students create a paper and mental image of the patient they are about to meet. In the outpatient setting where little information about the patient can be accessed from non-patient sources, the briefing focuses on collecting the data that would help a physiotherapist decide what to focus their attention on during the objective phase of the assessment. In both the ward and outpatient settings students receive only notional preparation for the sequencing of, and physical skills and practices required for, an objective assessment. In Figure 4.3b Lines 21 + 26 Verity tries to draw Lucy into a discussion about these issues but without success. In contrast, the more experienced staff take the approach of controlling the objective assessment themselves. In Figure 4.3a Line 7 Amelia, having perceived Verity’s anxiety, retracts the offer for Verity to lead the physical examination of the patient, while Julie does not even give Isobel the opportunity.

ii) Patient-focused placement interactions

Most therapy-focused interactions between neuro physiotherapists and patients lasted for 20-40 minutes. Analysis of the contact interactions suggests that each comprises three elements: settling into the interaction and determining the work of physiotherapy to be done; a physical contact phase; session closure and extraction from the interaction. While the length of time a therapist spent on each element differed with respect to the patient and setting, the three elements were consistently visible. The consistency of practice and the roles the patient, student and PEds took (or were placed in) during the interactions are
illustrated in this section using examples from ward and outpatient-based sessions led by the discipline-experienced PEds.

a. Settling into the interaction and determining the work of physiotherapy to be done

The examples I explore here took place in the ward and illustrate, through the verbal interaction between the PEd and her student, how the early part of a patient interaction is used to help the physiotherapist turn the mental image of the patient created from others’ notes into a real case appropriate for physiotherapy intervention. The examples illustrate practice consistency with both conscious and unconscious patients.

Appendix 1 Lines 83-119 follow Verity and Amelia’s first meeting with an elderly female patient on the ward. When the pair approached the patient she was asleep in her chair dressed in a nightdress and dressing gown. In Lines 84-86, while the patient dozes, Amelia and Verity screen her from the view of the other patients in her open ward and remove the wheeled table that is in front of her. In Line 88 the patient is woken by Verity and asked if they can ‘do your physio.’ The patient, new to the ward and perhaps also physiotherapy, asks Amelia, who is standing in front of her for an explanation. Having responded, Amelia passes control for the interaction back to Verity who, in Lines 92-97 appears to struggle to find the questions she needs to ask to translate the patient’s notes into a real patient case. Perhaps sensing Verity’s lack of direction, Amelia takes back control in Line 100. Amelia’s control of the interaction is evidenced by her managing two interactions simultaneously: asking seemingly disjointed questions to the patient and talking to the student (Lines 116-117). Amelia uses language e.g. ‘do a global assessment’, that Verity appears to understand but the patient does not. Amelia and Verity’s dialogue evidences an experienced physiotherapist deducing key physical changes in a patient from their ability to perform basic functional activities. Thus only 5-7 minutes after meeting the patient, there is a sense that Amelia has placed this patient’s needs in context and has identified a focus for the physical assessment that will follow (Line 120).

Figure 4.5 records the first few minutes of a student-present physiotherapy interaction with a semi-conscious ward patient. In this case Isobel (student) is working with Lucy (PEd). Lucy has recently left the rotation on this ward and is happy to be returning. Perhaps because of her confidence and familiarity in this workspace, Lucy adopts a different student-present interaction style on the ward than I observed in outpatients. On the ward Lucy verbalises the steps she is taking in her thinking as she creates a case of physiotherapy work from her exploration of certain features of the patient on the bed before them. The patient in Figure
4.5 is located in a side room off the main ward and attached to various monitors, a catheter bag and has a thick oxygen tube placed over a hole in his neck (a tracheostomy). Figure 4.5 Lines 1-25 follow Lucy through the first phase of her interaction with a patient whom she has not seen for a few weeks, and whom Isobel has never met.

Even though the patient in Figure 4.5 is very different from the patient in Appendix 1, there are a number of similarities in the physiotherapy interaction. Because the patient is unable to verbalise an update on his physical well-being, Lucy and Isobel discuss his nursing notes and the implications of the results they find there. The dialogue in Figure 4.5 Lines 4-8 was fully audible by the patient and, in common with Amelia’s dialogue with Verity, used language that they both appeared to understand, but which may have excluded the patient.

Figure 4.5: An experienced therapist helping a student identify physiotherapy work in the care of a semi-conscious patient.

Day 3: 10.30 am
‘X, it’s Lucy from physio, and we have a student called Isobel whom I think you saw yesterday, and a lady who is just watching’
Lucy and Isobel move to cubicle window where nursing notes are. Talk quietly.
Lucy: ‘Oh that’s good about his BP…..’[blood pressure]
Isobel: ‘What do you mean a bit low?…’
Lucy explaining and how to take BP on relaxed arm, just something to be aware of, might need to swap arms if pt’s tone high;
Lucy: ‘Always have a quick look - you can ask the nurses for handover, and they’ll say nothing is changed, but when you come you see x, y, z, so it pays to be aware that you don’t always get handover accurately’.
10.32 am
Walk back to patient, Lucy removing cot sides;
Lucy: ‘Nice and wide eyed X’;
Lucy: ‘Isobel so what do you see?’
Isobel: ‘Trache is looking a bit mucky’
Lucy: ‘We are awake, we are alert. What else are we looking at?’
Isobel: ‘Position….’
Lucy: ‘Yes and tone, how he is interacting with his base of support, how comfortable he looks. Always look at things around, how comfortable, how moving, make a good mental note before you go in…. X can you look over your left shoulder, can you turn head to me – nothing’
Lucy’s hand on pt’s head: ‘Let’s see if we can turn that head X’
Lucy to Isobel: ‘No resistance there, now I know X, so straight away I am thinking he is very tight. X we are just going to have a look at your arms and legs. So Isobel if you start’
Isobel moves pipes (humidifying tubes over trache) ‘X I am just going to start some little movements (see sketch)
In a scene again similar to Appendix 1, Figure 4.5 Line 13 evidences an experienced therapist determining the patient’s activities and controlling the interaction. Once patient contact begins Lucy asks Isobel to verbalise what she is noticing and deducing from her observations. Reminiscent of Verity, Isobel jumps in with a response in Line 16 that Lucy, like Amelia, finds inappropriate. In Lines 17-25 Lucy, like Amelia in Appendix 1, retakes control of the interaction and directs Isobel to notice the things that are important to help a physiotherapist identify an intervention focus.

Finally in this section, Figure 4.6 continues the interaction of Figure 4.4 Lines 12-19 to present the first contact phase interaction sequence between a new patient, an experienced therapist and her student in an outpatient setting. As described above, outpatient neuro therapists rely on the first phase of their contact time to elicit the scale and scope of their likely work. The first phase of the interaction (known as the subjective assessment) is thus longer and more question-based than on the ward.

Figure 4.6: The subjective phase of a new neuro outpatient assessment

1. Day 4: 2.38 pm
2. Julie goes to get pt. from waiting area. Smiles and welcomes (sit as sketch: Isobel with clip board is ready to start the subjective assessment of the new patient who sits unsupported on the plinth. Julie sits alongside Isobel emphasising the focus on the patient)
The patient in Figure 4.6 is a young woman referred to physiotherapy for outpatient-based rehabilitation from the hospital in which she received her acute-phase care. The patient was familiar with physiotherapy practice though not at this unit. Despite Julie having access to a detailed referral letter from the previous physiotherapist, she set the room up in an interview style (Lines 2-4 and proxemics sketch) and prepared Isobel with a question list. Isobel asks her first question in Line 6. The wording of this question seemed oddly formal at the time, but the flow of patient response and the lack of reaction from Julie suggested that this language style was familiar and expected. In Line 8 Julie is heard closing down and redirecting the patient’s response. Having retaken control, Julie mirrors practice seen with Amelia and
Lucy, and talks to Verity about the patient and her care while the patient waits. Unlike the ward situation however, there is a sense of conversation freedom in Lines 14-21 as the three participants appear to settle into a comfortable relationship with each other. But then, in Line 20, Julie takes control again and the business of data gathering is prioritised. Although Julie does not quiz Isobel about what she is thinking as she writes down the patient's response to her questions, it appears from Line 25, that Isobel is no clearer than Verity had been with Amelia about what sense she was supposed to be making of the information. In contrast, Julie, (Line 26) seems to have reached a decision about the patient's likely physical needs and thus the focus of the physical, objective phase of her assessment. In Line 27 Julie closes this phase of the interaction and marks the transition to the objective phase with the statement ‘If I can just have a look?’ Perhaps because of her previous exposure to physiotherapy interactions, the patient recognises this transition statement, and, in Line 28, undresses.

The three interaction sequences discussed here have evidenced the work being done by physiotherapists in the first few minutes of their face-to-face contact with patients. In each sequence an experienced therapist made physiotherapy data collection practices visible to the student. The PEd’s control of the patients’ environment and conversation seemed to be recognised and expected by the students. In all cases the students appeared to struggle to understand the information they generated from their patients and turned to their educators for help. The next section explores the objective, contact-based phase of the three interactions in Appendix 1 and Figures 4.5 and 4.6.

b. Conducting the physical assessment of a patient interaction

Appendix 1 Lines 120-176 follow Amelia and Verity’s assessment of their new, elderly female ward-based patient. Reviewing this phase of the interaction sequence as a whole suggests that there is an internal pattern to the therapists’ activities. Lines 122, 133, 154 and 174 suggest respectively that physiotherapists explore, using touch or ‘feel’, the patient’s freedom to move, their muscle strength to move against resistance applied by the therapist, the patient’s joint awareness (called proprioception), and finally how the movement ability and sensory awareness act together to co-ordinate functional activity - here walking. At each stage of the assessment process Amelia is heard narrating what she is doing with one side of the patient’s body before Verity is asked to repeat the activity on the patient’s other side. Thus together, with one therapist on each side, they perform the assessment as a symmetrical paired activity in approximately 20 minutes.
Within this broad assessment framework however, specific features of the interaction appear to be working to convey a sense that is not clear from the literal words spoken. Appendix 1 Line 125 is such a phrase. Through the question ‘Can Verity have a go as well so she can feel?’ Amelia makes the following visible to all interaction participants:

- Verity’s learner status,
- that physiotherapy student education here is framed about the practice of real patients in real situations,
- that the role of the patient is to provide the limbs for that practice, and
- that the work of physiotherapy is about doing things to bodies based upon the therapists’ determination of how limbs feel during their direct hand contact with them.

Amelia’s dialogue in Appendix 1 is crucial in helping Verity (and the patient and I) see the work of physiotherapy being enacted and co-constructed from the movement of the patient’s limbs. While the sense of a shared identity between Amelia and Verity is suggested in Line 150 when Amelia includes Verity in the interaction through her use of the word ‘we’, it is the way she talks to Verity, and Verity’s understanding of her words that shows their affiliation. Further, in Line 161 Amelia appears to be concerned about the accuracy of the data they are collecting from the patient and asks Verity to perform the sensation test in a more robust manner. Collectively these elements of the extract illustrate Amelia’s attempts to teach Verity the patterns of physiotherapy and, in so doing, evidence the processes by which physiotherapists create data from touch-based assessment practices.

Finally, with respect to the extract in Appendix 1, perhaps the most noticeable feature of the interaction sequence is the absence of the patient. While the patient is clearly in the interaction because the therapists are moving somebody’s limbs and charging someone with taking ‘a guess’ in one assessment test, the patient as a person appears to be absent. Perhaps because the interaction is taking place in the presence of a student, Amelia is performing her physiotherapy work and assessing the patient while also using it as a teaching session for Verity. In such a setting, while the work of physiotherapy is helpfully made visible to the observer, the patient in the interaction appears to recede.

Figure 4.7 continues the physiotherapy interaction between Lucy, Isobel and the semiconscious male patient in Figure 4.5. Through her words and actions in Figure 4.7 Lines 9, 13, 19, 21 and 30 Lucy illustrates for Isobel the way that physiotherapy here merges assessment and therapeutic practice i.e. that each touch-based event helps the therapist understand something about the patient’s limbs and to respond with an appropriate movement intervention to normalise the way the limbs move. In sequences almost identical
to those used by Amelia in Appendix 1, Lucy seems to be using the patient as a teaching tool. In this role the patient in Figure 4.7 is reduced to a passive object referred to in abstract terms (for example by Isobel in Lines 10-11 and Lucy in Line 33). When the patient does assert himself in Line 29, the therapists changed the pressure they were applying to his tight wrist but did not change their conversation style over him. In addition, throughout the 30-minute extract in Figure 4.7 Lucy, like Amelia, appears to draw Isobel into a shared identity through the use of the term ‘we’, and helps her to notice and think through the theory of their shared practice with this patient. Thus while the context and participants in Figures 4.6 and 4.7 differ, the activities they record make visible consistent practices and values with respect to the work the therapists are constructing, and the place of both themselves and their patients within this routine work.

A feature of the interaction in Figure 4.7 that differs from that in Figure 4.6 is the extent of Lucy and Isobel’s verbal interaction. The level of discussion that was undertaken while both participants were performing passive movements on their patient was remarkable, especially as, in Lines 31-44, it appears to have little to do with the tasks they were performing. Such dialogue might indicate Isobel’s confidence in her skills that enables her to talk while she acts, but may also suggest a more comfortable personal relationship between Isobel and Lucy, than Verity felt with Amelia.

Figure 4.7: The simultaneous physical assessment and therapy of a semi-conscious patient

<table>
<thead>
<tr>
<th>Line</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Isobel performs passive movements to X’s right elbow – silence. Isobel moving shoulder,</td>
</tr>
<tr>
<td>2</td>
<td>alarm goes (sat monitor)</td>
</tr>
<tr>
<td>3</td>
<td>Lucy smiles, waits for Isobel to realise OK</td>
</tr>
<tr>
<td>4</td>
<td>Lucy: ‘Are we worried?’</td>
</tr>
<tr>
<td>5</td>
<td>Isobel: ‘No if not accurate, looks OK’</td>
</tr>
<tr>
<td>6</td>
<td>Lucy: ‘Yes…’ explains ++ re what to look at if alarm goes ‘be aware, but don’t always need to stress about it’</td>
</tr>
<tr>
<td>7</td>
<td>Isobel returns to shoulder mvt</td>
</tr>
<tr>
<td>8</td>
<td>Lucy: ‘What are you feeling?’</td>
</tr>
<tr>
<td>9</td>
<td>Isobel: ‘He’s not ….perhaps there are some tissue changes, it does easily come away, he is not fighting me. (to X) .and backwards’</td>
</tr>
<tr>
<td>10</td>
<td>10.40am</td>
</tr>
<tr>
<td>11</td>
<td>Lucy: ‘So what are your thoughts here?’</td>
</tr>
<tr>
<td>12</td>
<td>Isobel glasses on: ‘Range of mvt actually very nice’</td>
</tr>
<tr>
<td>13</td>
<td>Lucy talking re ROM shoulder and how been maintained – challenge now wearing gowns as no need to flex arms to dress, Importance is for hygiene but problems later with function.</td>
</tr>
<tr>
<td>14</td>
<td>‘How about his hand?’</td>
</tr>
<tr>
<td>15</td>
<td>Isobel does mvt, offers ‘Oh that is something else I felt – a catch’</td>
</tr>
<tr>
<td>16</td>
<td>Lucy asks her to explain</td>
</tr>
<tr>
<td>17</td>
<td>Isobel shows happening in wrist too</td>
</tr>
<tr>
<td>18</td>
<td>Lucy: ‘OK so if you are testing tone what would you do?’</td>
</tr>
<tr>
<td>19</td>
<td>Lucy + Isobel discuss. Pt just lies between them.</td>
</tr>
</tbody>
</table>
Lucy tries to move X’s Left arm ‘Oh I can hardly move that at all.. you don’t like that do you my lovely?’

Lucy gently continuing to move while chatting calmly to Isobel re normal stiffness and just getting some mvt back

10.47am

Lucy + Isobel discussion re being immobile,

X: ‘That’s painful’

Lucy: ‘So what types of things would we be looking for?’

Conversation re splints and drugs, still moving hand

Isobel: ‘Skin break down’

Lucy: ‘So what would we do – focus on the hand or the whole body?’

Isobel: ‘Could we get the nurses involved?’

Lucy: ‘Have they got time….nooo’, smiles

Isobel: ‘Family?’

Lucy: ‘Yes, but what else, something more rigid’

Isobel: ‘Splints’

Lucy conversation re splints and drugs e.g. Baclofen while still moving wrist

Isobel: ‘Could have Botox into Biceps?’

Lucy: ‘Perfect’

Isobel: ‘Botox has done a fab job’

Isobel: ‘So he is keeping going himself now?’

Lucy: ‘Yes that’s right’

Tidy bed, replace cot sides and leave

Handwashing: CK to Isobel: ‘That was interesting, see him yesterday?’

Isobel: ‘Yes but PEd didn’t chat to me like that, so was really helpful’;

11.08am

Finally in this section, Figure 4.8 revisits the outpatient assessment introduced in Figures 4.4 and 4.6. Figure 4.8 is an extract from the first 10 minutes of the objective or physical phase of an assessment of a young female patient by Julie and Isobel.

Figure 4.8: An experienced PEd and student assessing a new neuro outpatient

Day 4 2.55 pm

Julie (PEd) to young female pt: ‘If I can just have a look?’

Pt takes off shirt to reveal sports top.

Julie moving pt’s right arm, chatting to Isobel about what she is feeling.

Julie to Isobel: ‘OK to have a go? Do a quick shoulder flexion, extension etc.’

Isobel does.

Julie to Isobel: ‘Can I have a feel? Have you had a feel for the tone?’

Isobel affirms, let’s go of pt’s arm and steps back.

Julie moving left arm talking to pt re how diagnosed, Isobel standing watching and playing with shirt button.

Julie to Isobel: ‘OK let’s have a look. Isobel, come around the back and have a look.’ (see sketch)
Julie and Isobel discuss shape of lumbar spine: ‘She is... her...’

Talk to pt from behind about back exs. [exercises]

Julie comes to front, demos some back exs in st, lying on floor and kneeling.

Pt to Julie: ‘That’s something I can’t do.’

Julie stretching right lower limb, explaining to Isobel why feeling tight and painful. ‘And then

the slump test...’

Interrupted by pt. Julie to pt: ‘Yes you know about that, well the nerves are a bit irritable

which they are in X (her condition).’

Julie to Isobel: ‘Do you want to have a go? Look at the invertors and evertors.’

Despite the change in context and interaction participants, the work being carried out by the
sequence captured in Figure 4.8 is similar to those in Figures 4.6 and 4.7. Julie, in Lines 2,
5, 7, and 11 makes clear to Isobel and the patient that at least part of the role of the
interaction, and the role of the patient within it, is to help Isobel learn to look, feel and
interpret what physiotherapy-related information she is seeing and feeling from the patient’s
body. Perhaps to help with the interpretation of touch into physiotherapy work, Julie uses the
language of physiotherapy (for example Lines 5 and 7) when talking to Isobel about the
patient. As with the other patients discussed in this section, the patient in Figure 4.8 is
referred to in the abstract as the therapists continue their dialogue around and behind her
(see for example Figure 4.8 Lines 7 and 11 and the kinesics sketch that captures Julie and
Isobel looking at the patient’s back while she sits still and faces the front). Unlike her fellow
patients however, the patient here tries to interact with the therapists using language which
suggests her ability to interpret and engage in physiotherapy talk (Figure 4.8 Lines 16 and
19). Julie’s response to this interruption (Lines 19-20) replicates Lucy’s in Figure 4.7 as she
reinstates her control by talking to Isobel in terms that return the patient to her role as
teaching model (Line 21).
The consistency of elements of the three interaction sequences discussed here suggest that a thread of core practices and values runs through student-present patient interactions at this site irrespective of the specific context or participants. In each case the educators have demonstrated, through their actions and dialogue with the student, that one purpose of the interaction was student education and that patients act as authentic audio-visual teaching tools within these interactions. Consistent across the interactions is thus the practice of learning by doing as students were taught to align what they were feeling through their hands with what they were seeing and thinking given their knowledge of the patient’s underlying pathology. Each experienced therapist used the language and vocabularies of physiotherapy to speak to their students and check their observations and understanding of their assessment results in the context of physiotherapy work. The language and practices of the educators did not appear to cause anxiety in the students suggesting that they were recognised as familiar and understood. Similarly the students’ questioning of their PEd received only positive responses suggesting that their abstraction of the patient’s limb from the patient was also acceptable practice. The physical contact phase of a patient interaction seems to be used to create the work of physiotherapy from the patients’ body movements and responses to therapeutic touch. When a student was present in the interaction the patient became an abstract object of the student’s learning.

Each scenario discussed here has been selected because it illustrates the typical patient interaction sequences when a student was in the presence of a discipline-experienced therapist. To conclude this section Figure 4.9 offers two snippets of field note data that follow the student-present patient-contact phases of interactions led by PEds who, while experienced educators, were new to the speciality and setting. Figure 4.9a records Lucy’s practice conducting a new outpatient assessment with Verity and Figure 4.9b follows Isobel working with Lorna with a semi-conscious ward patient.

Figure 4.9: The place of the patient in sessions led by inexperienced therapists.

<table>
<thead>
<tr>
<th>Figure 4.9a: Lucy acting as Verity’s outpatient PEd</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day 1, 11.45 a.m.</td>
</tr>
<tr>
<td>2 Verity: ‘OK so we will have a look at you’</td>
</tr>
<tr>
<td>3 Verity asks pt to transfer to bed, goes through assessment</td>
</tr>
<tr>
<td>4 Lucy alert, hovering until patient sat on plinth, watching ++</td>
</tr>
<tr>
<td>5 Pt smiling: ‘I nearly went flying there’</td>
</tr>
<tr>
<td>6 Lucy puts down plinth without telling anyone</td>
</tr>
<tr>
<td>7 Verity: ‘OK then, now if you can….can you for me…. Can you….’ Eye contact ++</td>
</tr>
<tr>
<td>8 …</td>
</tr>
<tr>
<td>9 11.55</td>
</tr>
<tr>
<td>10 Verity: ‘So now we have done all those tests we will look at your balance’</td>
</tr>
</tbody>
</table>
Verity: ‘Lucy will lower you down and I will get the sheet’

…

Verity reads first instruction, pt does, Verity struggles to set stopwatch

Lucy: ‘So what can you ask him now as he is standing there?’

…

Verity: ‘So which ones would you do next?’

Lucy: ‘I’d tend to do several in one position’

Verity asks pt to close eyes and repeat

Pt wobbles

Lucy: ‘I think I’d have been a bit closer’

Verity: ‘We will try that again’

Lucy: ‘You can see how his ankle strategy kicks in, you can see the dorsiflexors kicking in’.

Lucy talks to pt to explain what they have been saying, pt agrees he can feel it.

Figure 4.9b: Lorna and Isobel working with a semi-conscious ward patient

Day 4 ward bed screened by curtains, 1.56 pm

Lorna taking blood pressure, presses computer screen on ward wall above pt;

Isobel looking at screen, no discussion from Lorna about what doing or why;

Isobel writes BP on her glove;

Lorna: ‘What we want to try Z is sitting up. Is that OK? Yep?’

Lorna to Isobel: ‘Isobel you stay here, I’ll go behind OK?’ Isobel: ‘OK’.

1.58 pm

Lorna: ‘OK covered up’ points finger at Isobel, Isobel starts: ‘Z, can we get you to the edge of the bed?’

Lorna: ‘Do you want to put the bed down?’

Isobel: ‘Try and bring these legs towards me’; Strokes leg, ‘Can you feel me here?’

Lorna: ‘Isobel will help you move that leg’. Moves catheter bag. Isobel tries moving legs again.

Lorna on bed under sheet. Isobel: ‘OK Z, you are all covered’.

Pt grimaces. Lorna: ‘Is that the problem, was I on your hair? That’s it, leg right off.’

Isobel: ‘Bring this one with me Z.’

2.03 pm

Pt goes to lie. Lorna: ‘Still sitting up Z.’

Isobel initiates ‘Look at my hand Z, and up.’

2.15 pm Z now in sidelying, Isobel inserting sliding sheet, helping to roll and pull sheet through;

? Isobel has not got enough sheet.

Lorna: ‘Ready steady slide, tad more.’ Takes sheet out.

Lorna points to pillow on chair. Isobel blank.

Lorna: ‘Put it under the sheet, it holds better’ (pt in sly)

Lorna waving blanket – Isobel unsure ++ ‘For me?’ goes to take

Lorna: ‘No (Lorna holds blanket) you lift knee.’

Lorna puts blanket between knees instead of pillow.

Figure 4.9a offers snippets of Lucy’s practice as a PEd with Verity just four days after Lucy rotated to the neuro outpatient department from the ward. Unlike her practice in Figure 4.7, Lucy stands back and lets Verity lead the physical assessment phase of the interaction. For almost 10 minutes, from Lines 3-14, Lucy is quiet and does not interact verbally with the student or patient. Only when Verity appears to be struggling with the skills of the physical
assessment, potentially placing the patient at risk of harm, does Lucy begin an over-the-
patient dialogue with Verity.

In Figure 4.9b, while Lorna had been on the ward for four weeks by the time she had Isobel as a student, Isobel was her first student on the placement. Unlike Lucy, Lorna did not expect her student to carry out the new patient assessment unaided, but like Lucy she did not talk over the patient to explain what she was doing, what she was seeing etc. but instead only talked to the patient and student to direct the mechanics of the physical assessment. Lines 21-29 suggest that Isobel was at a loss to understand the responses and actions that were expected of her.

In sum, this section has explored participants’ interaction practices during the main patient-
contact phase of a neuro therapeutic session. The data suggest that in all cases of student-
present patient contact the focus of the interaction is on information gathering with patients placed in an abstract role as a teaching resource. Consistent differences between the interaction practices of experienced and inexperienced PEds suggests that the former articulate the sequencing and underpinning rationale for the practices being demonstrated. In these settings patients appear to be at less risk and the students less confused than when working with more inexperienced PEds.

c. Session closure and extraction from the interaction.

Patient-contact interactions ended with consistent session closure and leaving sequences. This section completes the patient-present data sets for the three main scenarios in this chapter. Although the ward scenarios see the therapists leaving the patient, and the outpatient patient taking leave of the therapists, the consistency of underpinning practices adds to the developing picture of the work of physiotherapy within this team. Students were not taught how to close a therapy session but took part in the sequences without direction.

Figure 4.10: Completing patient-contact interactions with ward-based patients.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Therapist</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amelia: 'Verity and I will go away.'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt: 'I am in your hands now.'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amelia: 'I'll leave you with Verity.'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt: 'Yes thank you, you get along now.'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verity and CK clear up bed area and put everything back, open curtains;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Say goodbye to pt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verity: 'We will come and see you tomorrow.'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verity carries walking frame away</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Communal hand washing joined by Amelia
3.06 pm In physio space behind nurses’ station.
Amelia: ‘What did you think?’

Figure 4.10b: Concluding an interaction with a semi-conscious patient
Tidy bed, replace cot sides
Lucy: ‘Bye X we will come back and see you again.’
Leave
Hand washing: CK to Isobel: ‘That was interesting, see him yesterday?’
Isobel: ‘Yes but PEd didn’t chat to me like that, so was really helpful’;
11.08
Back at nursing station
Lucy: ‘Right so let’s have a think about what was going on. What else could you have looked at?’

The field note extracts in Figure 4.10 capture ward-based physiotherapy closure and leaving sequences. In both Figures 4.10a and 4.10b the therapists return the patient’s bed area to its previous state before saying goodbye with a statement about their intention to return the following day. In neither case do the therapists discuss their observations from the therapy session with patient or offer any ideas for future intervention. While the patients will be aware that physiotherapists will ‘see’ them once a day, they would not know why or how the therapists’ ideas for their treatment were being developed. Both extracts also illustrate ward-based hand washing practices and the therapists’ return to their part of the nursing station. Later sections of the chapter will explore what therapists do when they come back to the nursing station, but Figure 4.10 suggests that, when time allows, the student can expect a debriefing with their PEd to follow each patient contact interaction.

Unlike the therapists in Figure 4.10 who can control their exit from the patient, outpatient staff achieve successful session closure when the patient leaves the therapy room. Figure 4.11 illustrates how this is accomplished by an experienced therapist.

Figure 4.11: Closing an outpatient-based neuro physiotherapy session
Julie to pt.: ‘Have you any other questions?’
Pt: ‘No it is nice to talk to someone who knows about what I am going through.’
Julie continues to complete duplicate exercise sheet for notes. Clarifies patient’s contact details and explains policy of not leaving messages as risk of breach of confidentiality.
Julie to pt.: ‘Grab your card and I’ll get the diary.’
Negotiate next appointment, confirm suitability of clothing.
Julie stands, hand on door handle.
Pt puts on coat, Julie opens door and Isobel stands by her.
3.50 pm
pt leaves ‘Bye ladies.’
Door closes. Julie to Isobel: ‘Nice lady, will you write it up?’
No hand washing.
In Figure 4.11 Line 1 Julie signals the closure of the session by offering the patient the opportunity to ask questions. The patient appears to recognise the closure signal and, instead of asking questions, moves to a phase of thanking Julie for her intervention. When the administrative tasks are completed, the exit phase of the sequence is highlighted by Julie reaching for her diary and the patient’s appointment card (Line 5). Each phase of the closure sequence in Figure 4.11 was visible every time a patient left the outpatient room. While the timing of the movement from question-asking to appointment-making differed, the most noticeably consistent practice was the therapist’s movement to standing with her hand on the door handle. This single action (illustrated in Line 7 above) was consistently followed by the patient (and their carer if present) reaching for their coat and hurriedly putting it on or putting it under their arm as they too stood and moved to the door. As the patient moved the therapist consistently opened the door saying their good byes as the patient left the room. The extract in Figure 4.11 concludes with Julie highlighting to Isobel that their work has not finished and that a writing activity is to follow. Unlike their colleagues on the ward, there was no hand washing in the outpatient team.

Figures 4.10 and 4.11 record events in different contexts and with different participants but at their core is the physiotherapists’ extraction from patient interactions. In each case the therapist appears to be in control of the interaction and the patient conforms to their control. At no time in any leaving sequence did a patient try to draw their therapist back into a discussion about their treatment, or any other conversation. In all three field note extracts discussed here there is a sense that the patients are passive recipients of physiotherapy. Even in the outpatient setting, where Julie (in Figure 4.11 Line 3) provided her patient with a list of home exercises, there is no sense that the pair has negotiated a plan of action for the patient’s next visit. The next section follows the students and PEds in their immediate away-from-patient activity which appears to create a physiotherapy-related case from the patient interaction the pair has just performed.

d. Creating physiotherapy work through dialogue and note writing

The field note extracts in this section complete the patient-related interaction sequences undertaken by students on the neuro placement. No matter how busy the PEds appeared to be on the ward, each patient-contact session was followed by a conversation before the students were asked to ‘write that up’. This section breaks the post-patient contact student experiences into three parts: the immediate post-contact debrief, a period of quiet note writing, and finally a session where PEds ‘signed off’ the student-created notes.
The post-contact debrief

The extracts in Figure 4.12 record the post-contact debriefs between Amelia and Verity, and Lucy and Isobel. Figure 4.12a is much shorter than Figure 4.12b reflecting Amelia’s busyness with activities other than Verity’s placement education. Lucy, as a visitor to the ward, appeared to have more time for Isobel.

Figure 4.12: Ward-based post-patient contact debriefs interactions

![Diagram](image)

**Figure 4.12a: Amelia checking Verity’s thinking about and learning from the patient contact session**

1. 3.06 pm in physio space behind nurses’ station.
2. Amelia: ‘What did you think?’
3. Verity offers
4. Amelia and Verity discuss ‘Slightly odd presentation’.
5. Amelia moving her hands ++ and stamping her foot when talking about pt. in standing;
6. Asks Verity why she thinks pt was stamping her foot. Offers ‘co-contraction?’;
7. Amelia: ‘Thinking more of a neuro emphasis? To increase stimulus, so she can hear her foot.’
8. Discuss future plans.
9. Amelia: ‘OK so can you write that up?’

**Figure 4.12b: Lucy debriefing Isobel following their patient-contact session**

1. 11.08 Back at nursing station
2. Lucy: ‘Right, so let’s have a think about what was going on. What else could you have looked at?’
4. 11.12 am
5. Lucy using her hands to demonstrate other activities they could have done with the patient: rolling, side-lying to sitting,… plenty of eye contact. Not looking at the notes, but at each other (see sketch below: Lucy on right gesticulating)
6. Lucy: ‘Last time I saw X he was… so I … it might be nice if you went on and did a proper assessment, we could ask Lorna… what are your thoughts?’
Figures 4.12a and 4.12b suggest that PEds take time immediately after a patient contact session to help students articulate, using the language of physiotherapy, what they have seen and done with the patient, and how these experiences are relevanced in the work of physiotherapy. In Figure 4.12a Line 7 for example, Amelia corrects Verity’s response to her question by requesting that she use terms with a ‘more neuro emphasis’. In Figure 4.12b and the proxemics sketch we see Lucy create a seated interaction space behind the nursing station on the ward. Both Lucy and Isobel appear relaxed in their interaction and Isobel makes notes for future reference.

PEds consistently drew the dialogue to a conclusion by helping the students discuss their ‘plans’ for the patient. These ‘plans’ were always discussed so quickly that I was unable to record any specific details other than a sense that they referred to what the therapists might do with the patients next time they met. The closure of the dialogue with a request for the students to ‘write that up’ suggests that a shared understanding had been reached by the PEd and their student, and that the student was now in a position to make a written record of the patient-contact interaction.

Creating a written record

Tracking students’ daily activities using time suggests that they spent about 15% of their time writing patients’ notes. As illustrated in Figure 4.13, this practice was frequently carried out in the presence of their qualified colleagues. Figure 4.13a is a sketch made in the middle of the morning on a neuro ward. In the sketch Lorna, Lucy and Gareth accompany Isobel (sitting on the left) in her note writing. With two therapists standing behind the counter using the ledge as a table, and two sitting at the desk, the team completely occupy the nursing station and leave a nurse only standing room against the wall to answer the ward telephone. Figure 4.13b captures a similar shared note writing time between Lucy, Charlotte and the student Stuart (on the right) in the outpatient office.
Figure 4.13: Note writing as a shared physiotherapy practice
Figure 4.13a: Communal note-writing in a ward setting

Figure 4.13b: Communal note-writing in the outpatient office

Given the time and communal effort taken in the activity of note writing, it was surprisingly difficult to pin down what was being documented and the work of physiotherapy that was being accomplished through the written word. As I had not asked permission to read notes in detail as part of the ethical approval for the fieldwork, I had to rely on the PEds’ verbalisation of note writing skills and their correction of the students’ efforts to make the practices of note writing visible. My field notes suggest that there were two forms of written record made by
the neuro team: the new patient assessment and treatment plan record, and the daily therapy record that reported on and developed the assessment record with each therapeutic intervention. In this section I use field notes and data from my 1:1 interviews with the neuro PEds to illustrate how students learn to write new patient records in ways expected at this site. Figure 4.14 follows Verity’s dialogue with Amelia after the PEd has asked Verity to ‘write that up’ (Figure 4.12a Line 10).

Figure 4.14: Structuring neuro physiotherapy notes

1 Amelia: ‘OK so can you write that up? Do you want a crib sheet to follow the headings?’
2 Goes to fetch, to CK: ‘Verity has not been on the ward much so still finding her way.’
3 3.10 pm
4 Amelia: ‘This is the form most people prefer to use the first time.’ Explains to Verity how it works.
5 Leaves Verity to write up assessment.
6 Amelia going downstairs to pick up an exercise mat for someone else. Smiles. Leaves.

Figure 4.14 suggests that Amelia is aware that Verity needs help to write her first neuro ward written record, and also that there is a set order in which the record has to be written. While I did not hear what this order was, it is clear from the brevity of the interaction (Lines 4-5) and Amelia’s confidence to leave Verity to write while she went and did other tasks (Line 7), that Verity shared an understanding of the terms and sequences highlighted in the offered template. Figure 4.15 is a snippet of the field note record of Amelia’s return and first discussion with Verity about the notes she has written.

Figure 4.15: Learning to write notes

1 3.44 pm
2 Discussing notes. Amelia clarifies need to state time started session.
3 Amelia clarifies re what Verity meant by gait assessment and balance control assessment’
4 Verity amends and initials changes.
5 Amelia: ‘Right, we will do the rest later. The next pt we are going to see is F…..’

The PEd: student interaction in Figure 4.15 suggests that, in addition to a template for structuring the notes, there is a protocol for amending them. While Verity is writing these notes on her fifth of eight four-week placements, and has written similar notes on ward-based placements elsewhere, she is clearly learning new elements of note writing with Amelia. During my post-observation interview with Amelia I asked her about the note writing protocol on the ward. While she did not offer explanations about the way notes were written, she did stress the legal importance of accurately constructed notes as illustrated in the interview transcript below.
39.49 minutes into the interview

Amelia: *I think it’s the more, I think it’s the way everything is going in medicine and the awareness that there’s more complaints and legal issues. It’s something that I’ve certainly become more aware of when I became a team leader, because I had more involvement in dealing with complaints.*

Thus in Figure 4.15 Amelia is careful to teach the student to both record the time of her treatment intervention (Line 2) and sign any amendments she makes (Line 4).

It took until the end of my second period of observation with the neuro team to find out more about the sequencing and content of physiotherapy assessment records. Figure 4.16 continues Julie and Isobel’s interaction about the new patient assessment introduced earlier in Figures 4.4, 4.6, 4.8 and 4.11. In Figure 4.16 the patient has left and, just before 4pm (with Isobel due to finish for the weekend at 4.30pm), Julie asks Isobel to write the rough notes she made from the subjective phase of the new patient assessment into the new patient record.

Figure 4.16: Making physiotherapy new patient assessment note writing visible

---

1. Julie to Isobel: ‘Nice lady, will you write it up?’
2. Isobel: ‘All of it or just the subjective?’
3. Julie: ‘Do the subjective and we can chat about what you want me to write for the rest.’
4. …
5. 4.00 pm Isobel writing notes on plinth.
6. …
7. 4.07 pm Isobel gets up from plinth and walks to Julie with notes;
8. Julie standing in office end reads;
9. Julie to Isobel: ‘Yep that looks good.’
10. Julie comes to bed area kneels down and Isobel, sitting on the chair tucks herself under the plinth: ‘So I would write the objective like this…’
11. Julie jots down order on scrap paper: ‘I find if you write things in the same order you won’t leave anything out.’
12. Julie writing on card, Isobel watching (sketch below)
Figure 4.16 is the only time I observed a PEd talking her student through the creation of an assessment record. The interaction suggests that the participants share a language and are comfortable in each other’s presence. While the extract illustrates the presence of an underpinning framework to the writing of an assessment record (Lines 11-12), it is clear from Line 44 that we are only seeing part of the note writing process. Figure 4.16 thus captures the use of physiotherapy language and a predetermined order to the writing down of assessment findings. What is not clear was what physiotherapists do with this written record. The planned end of observation interview with Lucy provided an opportunity to ask about the writing of neuro assessment records. From Lucy’s responses in the transcript extract below (Figure 4.17) I learnt the basic framework of and rationale for the record.
Lucy: I think they have recently changed, when I um... graduated it was all problem list, treatment plans, short term goals, long term goals and now it's impairments, activities, your treatment plan, your goals. But I think to say to a patient 'what is your main impairment' they are not going to have a clue. So, I think this is where the problem element comes in: you ask the patient what they are having problems with, um... but sometimes what they perceive as their main problem is not the impairment or not the problem. So obviously you have to do the assessment as well, to get a feel of what’s causing that to be a problem. So I suppose after an assessment, when I have a chat with the student about what does the patient feel their main problem is and then kind of how does your assessment match up with that, in order to be able to identify what the goals are.... (long pause)

CK: So, ... goals are... I'm just trying to put it all back into old language because I haven't done this for a few years. So, is there, I'm used to doing the SOAP notes, so you've got your subjective, objective, then the assessment and the plans. So are the goals the same as, they go before that then do they?

Lucy: Um... When you do your initial assessment we are prompted with the cards that we've, the new patient assessment cards that we've got, that you then write down the impairments, treatment plan and then goals. So it is separate from your SOAP notes. But I do find sometimes in a plan you may aim to achieve a goal so you might plan to do something to work towards that achievement.

CK: Yes. And how do you sort out the goals, are the goals usually to do with the impairments or the problems or?

Lucy: Again a bit of both. um... With all your CSP guidelines you're supposed to agree your goals with the patient, but obviously what a patient’s goal might be might not quite be your goal. The patient might just say 'oh I want to walk around without falling over', so you'll be like alright you want to improve your balance, therefore we'll do a BERG balance score so my goal is to improve your balance score, so they will be slightly different.

In Figure 4.17 Lucy differentiates between two distinct purposes of note writing (assessment and daily record: Lines 18-20) and the rules that governed their writing. Lucy’s response in Lines 1-11 also placed in context Julie’s comment to Isobel that ‘Next week you can think about impairments and then write that in’ (Figure 4.16 Line 44). Having written the data of the assessment out together, Isobel was being charged to work through it to uncover the impairments, or consequences for the patient’s function that arose as a result. Once the impairments have been identified, Lucy suggests that the physiotherapist creates a treatment plan to reduce those impairments and sets goals, or targets, by which the progress of the treatment plan against the impairments will be measured (Line 20).

The transcript provides a valuable insight into the rhetoric and practice of physiotherapy. In Lines 1-7 and 27-28 Lucy confirms that the language of physiotherapy assessments has changed, both nationally and locally, to enable the plans and goals of the ensuing
physiotherapy practice to be focussed on the needs of the patient undergoing the assessment. Lines 18-19 suggest that the printed physiotherapy records for the unit have been adjusted to reflect the change of language and focus. What is noticeable from the field note data presented here is that, despite the documentation changes, in practice no patient was involved in the creation of their treatment plan and progress goals. In both the ward and neuro outpatient settings therapists appeared to use patient-generated data to create lists of impairments, plans and goals at a distance from their patient. Lines 6-7 and 28-29 suggest that Lucy recognised the disconnect between rhetoric and practice, but her qualifying statements suggest that this practice was adopted because patients may not know what their real impairments are or how a physiotherapist would treat them. No student questioned the local note writing practices during either the observation or interview stages of the fieldwork for this study.

**Signing off the written record**

Each physiotherapy record must be signed off by both the student who has written it and their supervising PEd every time a new entry is made. In the outpatient setting the signing off I observed was cursory with no recommendations for adjustments made. On the ward however, this final phase of the patient-related interaction was usually detailed. Figure 4.18 follows Isobel through three ‘signing-off’ phases with three different ward therapists.

**Figure 4.18: Learning to write treatment records ‘the way they like it here’**

<table>
<thead>
<tr>
<th>Day 3: 11.47 am</th>
<th>Isobel just finished writing patient’s record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isobel passes card across desk to Lucy who is waiting for it. Lucy kneels down by desk and starts to read. Isobel waits quietly and still; Lucy (still looking at notes): ‘Um., you could have just mentioned that pain was evident….’</td>
<td></td>
</tr>
<tr>
<td>Isobel: ‘So shall I pop it in here?’ Points and writes, signs Lucy: ‘It is a hard line to find. You don’t want to write stories… but your notes are a good way to show your thought processes – yes the facts but how do we know you are thinking….’</td>
<td></td>
</tr>
<tr>
<td>Lucy and Isobel continue talking as other physios come and go to desk.</td>
<td></td>
</tr>
<tr>
<td>11.53 am Lucy: ‘We just need to read that you are thinking the right things, I am sure you are, you seem to be but…. Signs record and hands back to Isobel Isobel adds notes to pile, stands and goes to find Lorna.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day 3: 2.30 pm</th>
<th>Isobel gives notes to Lorna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorna: ‘So if I were you, I would go obs, legs 5/5, then balance…’ Discussion re notes and how to use SOAP, ‘S is more subjective…’, ‘O is more objective…’ Isobel: ‘OK’</td>
<td></td>
</tr>
<tr>
<td>Lorna reading carefully. Isobel twisting awkwardly towards her (see sketch: Gareth writing notes on far right)</td>
<td></td>
</tr>
</tbody>
</table>
Lorna: ‘Hmm. You could put that… hmm (pondering), so perhaps balance re-ed in standing static perhaps?’
Isobel writes qualifiers on notes
Lorna signs and closes. ‘OK’ discussion turns to next patient
2.34 pm

Day 4 9.38 am
Gareth reading Isobel’s notes, querying order: ‘They like a certain order here, you have done respiratory before obs so…’
Isobel gets small note book out from her trousers
Gareth to Isobel: ‘Yes write it down. . (see sketch below: Gareth on left leaning on nursing station)

Gareth: ‘Do obs, so CNS, GCS and orientation, CVS including everything to do with respiratory then subjective: what the nurses told you; then objective as above and about positioning; then treatment: what you did.’
Isobel: ‘Great, cool’
Gareth: ‘That’s about it really, just make sure you sign it.’
Each of the brief interactions in Figure 4.18 illustrates an element of the ward note writing process. In Line 4 Lucy suggests that the expression ‘pain was evident….’ be added to the record. This formal turn of phrase is unlike the language the pair has used verbally within their interactions with each other or their patients. Further, in Lines 6-7 and 10-11 Lucy advises Isobel to write as if she is trying to illustrate her thought processes – and thus doing more than simply reporting the findings of her daily assessment and interaction. Both Lucy’s recommendations suggest that the written record is a deliberate construction of physiotherapy work.

Later the same day Isobel needs a card signed off by Lorna, her named ward PEd. During this interaction Isobel learns about the broad structure of a daily record (Lines 14-15) and receives further feedback that the language she is using to write the notes is not that which Lorna would have used (Line 20). The short phrases used by Lorna during the interaction (Line 15) and Isobel’s minimal verbal responses (Line 17) suggest that the pair share a different relationship than Isobel had with Lucy. The kinesics sketch accompanying the interaction illustrates Isobel’s closed body posture and perhaps confirms a lack of easefulness in Lorna’s presence.

Perhaps the most helpful interaction sequence about note writing occurred in Figure 4.18 Lines 25-35 when Isobel had a signing off discussion with Gareth. Gareth was a Band 5 therapist who had been qualified for just over a year and was on his fourth post-qualification rotation. The accompanying kinesics sketch records Gareth and Isobel’s open body language and suggests a comfortable relationship between them. Gareth’s opening statement in Line 26 demonstrates his understanding that, within a core framework, each physiotherapy team has local expectations for written records. Perhaps because he remembers his experiences as a student, Gareth takes time to spell out the specific note writing format that he thinks this team requires. In Lines 31-33, Gareth helps Isobel (and me) to see how the broad framework of SOAP notes described by Lorna in Line 16, translates into this neuro context. Gareth’s use of abbreviations in Line 31 makes clear the formal, medical nature of the language that is expected within the notes. In discussions with Isobel after this interaction she expressed gratitude for Gareth’s clarity which not only enabled her to write better notes, but also to record (on her hand or a glove) the patient’s observation data (blood pressure, oxygenation etc.) at the start of a patient contact session.

In summary physiotherapists spend a large part of their day writing records about their patients. While ward therapists draw on the written records of doctors and nurses to compile the initial database for patients, physiotherapist notes are used only by physiotherapists. If
therapists need to communicate any patient changes or concerns to other health professionals, they write short entries into the patient’s medical notes or nursing cardex. With therapists frequently co-treating different combinations of patients, it was common for them to read and add to each other’s notes. Perhaps because of the inter-team use of the notes, there was a strong sense of note writing practice consistency within the teams on the wards and in outpatients. Although detailed analysis of the patients’ notes was not possible as part of this study, the field note and interview data have evidenced the language that is used to write them and the physical distance from the patient at which they are written. Collectively the study data suggest that physiotherapy notes are constructed to create physiotherapy from an assortment of patient data. The patient themselves are the providers of the necessary data, and the recipients of the work that is created, but appear to be otherwise absent from the record-making process. In this study each student seemed to understand the basic structure of note writing but learnt the locally required specifics through practice and snippets of feedback from their qualified colleagues. At no time did a student on the neuro placement question the place of the patient in the note writing process. In both the ward and outpatients settings the note writing process was a quiet, companionable practice. As staff completed their records they went their different ways to treat more patients before regrouping for further periods of writing and ward administration.

This section concludes the discussion of neuro placement data in the main thesis text. Appendix 3 illustrates students’ learning experiences in multi-therapist: one patient interactions. The accompanying discussion is not included here for reasons of space and to keep the text focused on 1:1 PEd: student settings. The main outcomes from Appendix 3 are evidence that, in multi-therapist settings there appears to be a hierarchical order to the body-parts therapists are allocated, and that physiotherapy work is not verbalised. The possible impact of the latter on patient risk is also discussed.

4.9 Chapter summary

This chapter has drawn on empirical observation data to make visible the typical placement learning experiences of students on a neuro placement at the study site. Subjecting the rich, multi-faceted data to cycles of exploration has uncovered patterns of physiotherapy practice from the seeming blur of practices that made up the neuro team’s daily work. The evidence presented in this chapter suggests that, in line with Amelia and Charlotte’s intentions (Figure 4.1), the emphasis of the students’ learning experiences was on learning-by-doing.
The field note extracts have illustrated consistent ways in which placement educators created learning opportunities from the students’ co-working and observation of their clinical case load. Throughout the field work, except where students were used explicitly as extra pairs of hands (Appendix 3), the focus of their patient-related activities was to learn the different elements of practice that created the work of physiotherapy here. All educators prepared students for a patient-interaction with a theory-based briefing that concentrated on the medical diagnosis of the patient and their probable related physical presentation. Gathering information from non-patient or patient sources was a typical focus of the pre- or early contact phases of a patient interaction. Interpretation of this data directed the therapists’ physical intervention during the main phase of the interaction.

Irrespective of the PEd working with the student, the patient-contact interactions appeared to abstract the patient from their body and create an interaction where ‘the body’ was the focus of the therapists’ work. Students were frequently invited to ‘look at’ and ‘feel’ a limb and articulate what they were seeing and feeling using the language of neuro-physiotherapy. When the patient-contact interactions were led by discipline-experienced PEds, the practice and reasoning of physiotherapy in the activities being performed were made explicit for the student in front of the patient. After the session students’ learning was consistently focussed on creating a written record of their interaction with the patient. The students’ patient-related work typically ended with the patient’s written record being signed off by their supervising therapist.

Analysis of the PEd and student interactions illustrated in this chapter suggests that the third year students shared a language and framework of work practices with their qualified peers. Thus, while the extracts of interactions between discipline-inexperienced PEds and their students appeared to generate visible uncertainty in the students’ patient-contact practice, there was a smoothness to their pre- and post- contact activities that suggested these were anticipated, and had been experienced and/or rehearsed before. Throughout the chapter the data have evidenced consistently that physiotherapy is created within a framework of medical terminology and drives practices that translate data about patients’ bodies, gleaned through observation and touch, into visible and robust data.

This chapter and its accompanying appendices have created a sense of the lived experience of a Week One third year neuro placement. Now we turn to the musculoskeletal (MSk) data and explore the typical placement interactions of students in that physiotherapy speciality.
Chapter 5: Experiencing a musculoskeletal placement.

5.1 Introduction

The second site of observational fieldwork for this project was a musculoskeletal physiotherapy outpatient department. Musculoskeletal physiotherapy describes the work of therapists who focus on the treatment of non-neurologically induced soft tissue problems. The core work of therapists in this specialism is the management and rehabilitation of patients with muscle pains, joint sprains, or recovering from joint surgery or bone fractures. Patients attend the department from home on referral from their General Practitioners, hospital consultants or other physiotherapists. While patients may be in physical pain and have movement limitations, they are generally in good mental and physical health. A large number of physiotherapists work in the department with their patient case load coordinated through a department-wide electronic diary system.

Outpatient-based musculoskeletal physiotherapy (MSk) was selected as a focus for this study because, like neurology, it is defined by the National Curriculum Framework (CSP 2002) as a ‘core’ speciality. Most students from the study University have two of their eight undergraduate placements in this specialism. As an entirely non-ward-based working space, the MSk placement provided an excellent foil to the neurology placement as a site to explore student placement learning experiences.

This chapter uses data from fieldwork observation and participant interviews to set out the typical everyday practices and interactions of students and placement educators in an MSk placement. The chapter has been written after the ‘neurology story’ and demonstrates a progression in my noticing the interaction practices that appeared to be recognised by the students and their PEds as everyday performances of physiotherapy at this site. More confident in my understanding of action as socially mediated and accounted practice (Gubrium and Holstein 2000), I use this chapter both to describe the interactions I observed and, where I feel resonances occur, discuss these in the discourses of the established interaction analysis literature. This integrated approach deepens but also lengthens the discussions. To do justice to the work I have undertaken, and the practices of the people I was privileged to observe, I have made specific decisions about the chapter’s structure.

The main text mirrors Chapter 4 and focusses on the students’ typical patient-facing placement experience. Reflections arising from my access interviews and discussions about learning in supplementary sites (i.e. hydrotherapy and staff group skills training sessions)
have been developed into case studies provided as Appendices 5 and 6. While important to synthesis discussions in Chapter 6, these case studies act as adjuncts to the main MSk story so only key features will be brought forward here. The text here sets the placement in context and then follows the students as they experience department-based learning with their placement educators (PEds). The chapter concludes by exploring the observed practices for consistent interaction patterns.

5.2 The context and planning of a musculoskeletal placement at this site

The daily work of MSk physiotherapists at the study site had two foci: ‘core’ work and ‘a duty’. ‘Core’ activities focus on the management of a MSk patient list allocated to therapists from the pool of referrals received by the whole department, and ‘a duty’ is an additional activity (or activities if each duty is considered to be ‘small’) that may or may not be patient-facing or be located in the same physical space as the ‘core’ work. Examples of duties include placement education coordination, hydrotherapy and emergency clinic triage. Each ‘duty’ is led by a senior member of the MSk departmental staff.

Ian (a Band 8 Clinical Specialist) was the Duty Leader for MSk placement education and developed the local vision and rationale for placement provision. Megan (Band 7) and Naomi (Band 6) were assigned to Ian’s ‘duty’ to organise a rotation system of teams of three PEds (one Band 7 and 2 Band 6s from a group of 20 staff) to lead the students’ learning for each placement. Appendix 4 tracks my journey through the access interview data with both Ian, and then Megan and Naomi to map how Ian’s vision for the ethos and practice of education translated into broad placement aims. Here I summarise the key features of that discussion to foreground our exploration of the ‘core’ MSk student learning experiences of this placement.

i) The University’s intention for MSk placement education

Table 5.1 records the University’s Intended Learning Outcomes (ILOs) for Year 2 and Year 3 MSk placements that apply to musculoskeletal placement education wherever that placement is offered. All students are assessed on the same end of placement proforma, and placement educators are free to develop the students towards this assessment over four weeks in ways that suit local needs and practices.

9 The use of the word ‘duty’ is interesting in this context. The OED offers several definitions for the term which include the following: ‘Duty: an expression of due respect, reverence; or an action or act that one is bound to do – an obligation.’ Discussions with staff suggest that duties are seen as secondary to ‘core’ work and approached as an obligation.
Table 5.1: MSk related ILOs

By the end of the placement the learners will be able to:

<table>
<thead>
<tr>
<th>Year 2 (Level 5)</th>
<th>Year 3 (Level 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Manage with guidance, patients with a musculo-skeletal problem;</td>
<td>- Manage, with decreasing guidance, patients with increasingly complex musculo-skeletal problems;</td>
</tr>
<tr>
<td>- Demonstrate they are cognisant of the functioning of the department, e.g. a</td>
<td>- Participate in the administrative procedures of the department e.g. discharging, referring on and clinical audit;</td>
</tr>
<tr>
<td>diary system, discharge procedures, roles of other staff and referring on;</td>
<td>- Practise good personal time management;</td>
</tr>
<tr>
<td>- Practise, with guidance, the processes of personal time management e.g.</td>
<td>- Demonstrate proficiency at the basic skills taught in college, and on previous orthopaedic experiences, with patients with increasingly complex conditions.</td>
</tr>
<tr>
<td>efficiency with patients;</td>
<td></td>
</tr>
<tr>
<td>- Demonstrate they are proficient in the basic skills taught in the College block</td>
<td></td>
</tr>
<tr>
<td>and in new skills they have been introduced to on placement.</td>
<td></td>
</tr>
<tr>
<td>- Manage, with decreasing guidance, patients with increasingly complex musculo</td>
<td></td>
</tr>
<tr>
<td>- skeletal problems;</td>
<td></td>
</tr>
<tr>
<td>- Participate in the administrative procedures of the department e.g. discharging,</td>
<td></td>
</tr>
<tr>
<td>referring on and clinical audit;</td>
<td></td>
</tr>
<tr>
<td>- Practise good personal time management;</td>
<td></td>
</tr>
<tr>
<td>- Demonstrate proficiency at the basic skills taught in college, and on previous orthopaedic experiences, with patients with increasingly complex conditions.</td>
<td></td>
</tr>
</tbody>
</table>

ii) The local vision and organisation of MSk placement education

During our access interview Ian stated that he ‘specifically designed (placements) with three elements: the technical aspect, a knowledge base and clinical reasoning… with less emphasis on the knowledge than the others because they get that in College’. Irrespective of which year the student was in, Ian wanted them to leave the MSk placement with good technical skills and ability ‘to clinically reason their patients’. In the interview Ian explained that he had decided on these foci ‘because, it’s no one’s fault, but I’ve done teaching in the College and I was struck by the little practice time, so they need practice at skills’… and for their ability to ‘clinically reason their patients… [pause] We are teaching them to fish, to go through the processes of working out what is going on [with a patient] when they [the patients] say x, y, z.’

To give students the opportunity to achieve his placement aims Ian designed a placement format that takes two students at a time with their learning managed by three therapists in a predetermined timetable routine. The ‘technical aspect’ of the students’ placement is catered for in three ways: firstly, taking two students at a time means that ‘they can model for each other’ in PEd-led skills teaching sessions; secondly, the students’ daily timetable from 8.30-9.30 a.m. is blocked out for ‘preparation and skills practice’ when Ian expects them to practise the skills they think their day’s patients may need; and thirdly, twice a week their timetables are blocked out from 12.30-1 p.m. for ‘Techniques’. The ‘Techniques’ sessions
are a skills-development activity that is built into all the MSk therapists’ timetables. The half-hour sessions are peer-led and enable therapists to practise the ‘techniques of the day’ on each other. Students are required to join in this activity.

Development of physiotherapy thinking (clinical reasoning) is achieved by ‘dedicating the educators to the students’. For the time that a PEd is allocated to the students they will not have ‘their own patient list’ and are thus ‘dedicated’ to the students. Ian described this practice as ‘confirming the importance we place on getting the students to be good at clinically reasoning’. Involving three therapists as a team of PEds reduces each person’s case load to some extent but also ‘gives them space to get away from the students… in the nicest possible way… and keep up their lists.’ However, while the PEds drop their ‘core’ work for the days they act as PEds, their duty (secondary) roles continue. In a system where PEds are dedicated to their students the ‘duties’ were one of the few times when students saw their PEds at work with patients. For every placement Megan and Naomi thus created an outline four week timetable for each student, allocated a PEd ‘set’, and blocked off ‘dedicated’ days into the onscreen diaries of the three therapists in each ‘set’. With about 20 staff available for PEd allocation, and each having a different ‘duty’ combination, we can see Megan and Naomi’s challenges and the diverse learning opportunities potentially available to each student pair.

This implicit placement variability is reminiscent of elements of the ‘organisational accountability’ Button and Sharrock describe in their ethnomethodological study of engineering project management in a technology company (1998). Button and Sharrock discuss how ‘local managerial practices and dispositions’ (p. 97) can conflict with ‘organisational imperatives’ (p. 85). In the context of MSk placement education, the students will not know that their placement experiences are any different from those of their peers and will be working to achieve a placement assessment score within the scope of their provided timetable. The challenge of the MSk department here is to reconcile the students’ diverse learning activities and educator combinations created by well-intentioned local planning practices, to ensure consistent opportunities for students to pass the generic, cross-placement assessment process. In Button and Sharrock’s study their engineers were unaware that a major part of their work practice was accounting for these internal inconsistencies in a concerted organisation of activities ‘to make do’ within a given context (Button and Sharrock 1998, p. 88). The challenge for the current study is to make visible these every day, normal practices in the context of physiotherapy placement education.
From vision to practice: the development of students’ placement timetables

My access interview with Megan and Naomi provided factual information about the MSk placement organisation and, through their use of verbal and body language, a strong sense of shared understandings. The transcript of the interview has been explored in detail and forms the major part of Appendix 4. This analysis suggested two distinct differences between the focus and practice of neuro and MSk placement education. Firstly, the MSk team place emphasis on students’ ability to clinically reason (CR) and adopt two specific practices to achieve this: they explicitly break student: patient interactions down into segments to facilitate the reasoning through of each step in the students’ patient care and, because this process takes time, students have longer patient appointments and further ‘Feedback’ slots built into their computerised diaries. The prominence of CR, the language used to describe its local practice and the resonances between my reflections on the interview transcripts analysis and Garfinkel’s thoughts about ‘local accounting practices’ (1974b, p. 17) and thus the cultural setting for the MSk placement, are discussed in detail in Appendix 4.

The second noticeable difference between the neuro and MSk placement organisation is the way patients are selected for student practice. In Chapter 4 we saw how Amelia (the neuro PEd Lead) organised her team’s workload around ‘cases’ that she had selected as ‘interesting for the student to see’. Student and PEd then worked together through this patient list with a sense of shared endeavour. In contrast, in the MSk context, once Megan and Naomi had structured the electronic timetables as discussed above, these were accessed by the departmental administrator who filled available slots with patients. Thus MSk PEds had no involvement in the selection of patients for their students’ first weeks on placement.

In summary, local organisational accountability (in terms of patient throughput, record keeping and central diarisation), together with team-specific privileging of techniques practice and clinical reasoning development, combine to frame the learning opportunities that are available to MSk students. While students are assessed at the end of four weeks against criteria that are consistent across specialities and placement sites, local expectations and accountability frameworks may impact differently on their individual learning potential. Analysis of the access meetings thus suggested that my observation should explore how students were helped to assimilate into, and maximise their learning from, ‘the complex web of relationships, material artefacts and activities’ that make up ‘the texture of practices’ at this site yet may differ from those of their previous experience (Gherardi 2006, p. 2).
Section summary

By the end of the access interviews it was clear that this MSk placement was underpinned by a very specific vision and that the way the vision was turned into practice impacted on the types of learning experiences that were available to the students. Through my discussions with Megan and Naomi I knew that the students would each receive a timetable on arrival with slots already booked out for specific activities. The sense of linearly organised time-controlled practices suggested that more orderly field work observations and note taking might be possible here than occurred in the neuro ward setting. The interviews foregrounded the basic pattern of work and enabled me to locate myself in their practices very early in my observational fieldwork. The next section of this chapter will thus take the reader straight into the field to experience the practical accomplishment of MSk placement education at this site.

5.3 Students' 'core' work patient-facing interactions

This part of the chapter contains the main empirical data from the fieldwork observing students on their MSk placement. As outlined at the beginning of the chapter, the focus here is on students’ patient-facing learning experiences. Exploring the data illustrated that, as Ian suggested, ‘clinical reasoning’ and ‘techniques’ learning experiences were essentially distinct activities. With very few exceptions, clinical reasoning education was the focus of students’ patient-facing interactions, while techniques education occurred without direct focus on or relevance to specific patient need. This section thus draws on my written field notes, proxemics sketches and kinesics staves to make visible the patient-facing elements of the students’ placement. Although students worked with patients in both ‘core’ and ‘duty’ areas, I focus here on their ‘core’ activities. The learning experiences provided by their ‘duty’ (hydrotherapy) have been extracted to form the case study in Appendix 5. Similarly students’ skills-specific learning occurred in several distinct situations which have been collated into the case study in Appendix 6.

i) The context of students’ typical core MSk placement experiences

The ‘core’ work of the MSk team takes place in individual cubicles within large Treatment Rooms. A cubicle is a therapy space created by curtains drawn to divide an open room into sections. Each section fits a plinth, a wooden chair, and sometimes a small table. The plinth is usually bare except for one pillow. Plinths line facing sides of the room and indicate how many patients can be accommodated at one time. Curtains were drawn back against the wall when cubicles were not in use. An area on one wall housed a sink and tables and chairs
strewn with notes that suggested they were the staff desks. The walls at this site were painted pale blue with anatomical posters hanging by the entrance from the waiting area. The radio was frequently on and there were no personal artefacts (bags, photos etc.) to be seen.

My observations occurred on Days 1 and 2 of the second week of the four-week MSk outpatient placement. Over the course of six full days of observation I saw 6 students working with 5 PEds as illustrated in Table 5.2. In each Block the PEd set comprised an experienced Band 7, an experienced Band 6 (i.e. a therapist specialising in MSk physiotherapy having completed their generalist Band 6 rotations), and a newer Band 6 therapist who had either recently joined the MSk specialist team, or was rotating through it.

Table 5.2: The students and PEds I observed for this study. Students in bold were the main focus of each Block’s observation.

<table>
<thead>
<tr>
<th>Block</th>
<th>Students</th>
<th>PEd set</th>
<th>Observed?</th>
<th>Interviewed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emily</td>
<td>Anna (Band 6) Amy (new Band 6) Angharad (Band 7)</td>
<td>Day 1 + hydro Day 2 No</td>
<td>No No Yes</td>
</tr>
<tr>
<td>2</td>
<td>Gareth</td>
<td>Brian (new Band 6) Karen (Band 6) Belinda (Band 7)</td>
<td>Day 3 pm clinic duty obs No Day 4 + hydro + Day 6 hydro</td>
<td>Yes No Informally</td>
</tr>
<tr>
<td>3</td>
<td>Louise</td>
<td>Caroline (Band 6) Chloe (Band 6) Anne (Band 7)</td>
<td>Day 5 (Day 6 ad hoc) No No</td>
<td>Yes No No</td>
</tr>
</tbody>
</table>

Table 5.2 offers a snapshot of the PEd sets that supported the students’ learning in each placement block. Preliminary data exploration suggested that learning opportunities during patient-facing interactions differed across all Blocks dependent upon two factors: the PEd’s level of experience in the speciality, and whether the patient contact occurred during core or duty activities. A consistent feature of all placements at the time of my observation was the emphasis on new patient assessments. The rest of this chapter uses extracts from patient-facing interactions with Belinda (Band 7), Caroline (Band 6) and Amy (new Band 6) to illustrate the range of learning experiences I observed.

A challenge in writing this chapter is to help readers experience how placement education is accomplished when students are either on their own when working with patients, or being observed by their silent PEds. As we saw in Chapter 4, neuro students learnt practical and thinking skills while working alongside their PEd. When the neuro PEd was an experienced clinician we saw how they narrated their activities so that the students (and observer) could
see and learn the physiotherapy in their actions. In contrast the typical MSk placement scenario was for students to lead the patient therapy session and be taken out of the therapeutic interaction at key points for away-from-patient discussions with their PEds. Thus the typical patient-related learning / teaching sessions were not patient-present but clustered in away from patient discussions. The primacy of these PEd-led briefings as learning opportunities has influenced the selection of cases presented in this thesis. Both Caroline and Belinda sat in on elements of their students’ new-patient assessments while Amy always stayed at her desk until approached by the student for a briefing discussion. Analysing the field notes suggests that having a PEd present during patient contact sessions did not influence the practice of that student, but did appear to impact on the briefings. In the sections that follow I thus track the students’ patient-related practices and discuss how learning is practically accomplished with respect to the elements of the students’ practice that the PEds discuss, and those that they appear to ignore.

Data analysis suggests that each new patient-related interaction was structured around the following consistent pattern: pre-patient preparation, settling the patient and conducting the subjective assessment, away-from-patient PEd debrief, objective assessment, away-from-patient PEd debrief, advising the patient and closing the session, post interaction PEd debrief, note writing and note signing off. I use empirical data to evidence each of these phases in turn.

   ii) Preparing to see a new MSk patient

Figures 5.1 and 5.2 illustrate the typical PEd involvement in students’ preparation to undertake a new patient assessment.

Figure 5.1: Caroline’s first interaction with the students on her PEd day
The interaction extract in Figure 5.1 illustrates three consistent features of PEds' early morning conversations with their students: their brevity, the focus of the interaction and the management of the 1 PEd to 2 students context. Typically the first pre-patient discussions of the day followed the students' daily timetabled hour of self-study and peer-supported skills practice, and started two or three minutes before the patients were due to be called. It was common for students to be unable to access the patient database before the arrival of their PEd. While Figure 5.1 Line 1 suggests that the reason for Caroline’s absence was that she was seeing her own patient list, this was not the case on the other occasions when similar practices took place. Figure 5.2 illustrates Amy’s introduction to the students on her PEd day.

Figure 5.2: Preparing two students for their simultaneous new patient assessments

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.23 am</td>
<td>Amy comes over to student corner: ‘Hello, I am your educator for today. So you have both got new patients who are in. Anything you want to go through before?’</td>
</tr>
<tr>
<td>9.24 am</td>
<td>Emily: ‘Yes the X-Rays please.’</td>
</tr>
<tr>
<td>9.25 am</td>
<td>While computer loads Amy talks to Diane about her patient, Diane leaves.</td>
</tr>
<tr>
<td>9.26 am</td>
<td>Amy and Emily looking at pt’s X-Rays on screen.</td>
</tr>
<tr>
<td>9.27 am</td>
<td>Amy: ‘Would you expect her to have degenerative changes?’</td>
</tr>
<tr>
<td>9.28 am</td>
<td>Emily responds</td>
</tr>
<tr>
<td>9.29 am</td>
<td>Amy: ‘She has got.. hasn’t she. Can you see some degeneration? So something to bear in mind. What about the gleno-humeral joint?’</td>
</tr>
<tr>
<td>9.30 am</td>
<td>Emily answers;</td>
</tr>
<tr>
<td>9.31 am</td>
<td>Amy: ‘Well it looks OK, nice space I think. OK fine.’</td>
</tr>
<tr>
<td>9.32 am</td>
<td>9.30 am Emily goes to get body chart and then the pt.</td>
</tr>
</tbody>
</table>

The short interaction extracts in Figures 5.1 and 5.2 are replicated throughout my field notes and demonstrate a consistent conversation focus on the internal body structures of the patients the students were about to assess. In both extracts the actions of the PEds to load up the online patient database suggest that a request to do this was the expected response to their offer of preparatory support. Through their language and practices the PEds then hone the students’ attention onto the specific body part labelled in the referral letter. In Figure 5.2 for example, Amy turns the shoulder into ‘the gleno-humeral joint’ (Line 10). Within just a few minutes the educators appear to be ensuring that the students can see (physically and metaphorically) the case for physiotherapy in the short referral letter and accompanying onscreen X-Ray. While the length of time spent in this preparatory activity is markedly shorter than those experienced by the neuro students, the work being performed by the interaction is similar in both placements.
In their ethnomethodologically informed study of teachers teaching science to American primary school children Lynch and Macbeth describe four teacher practices that resonate with elements of MSk placement education at this site. Lynch and Macbeth (1998) suggest that classroom science lessons comprise four consistent interaction sequences which they describe as working to:

- Position and discipline the witnesses
- Manage and orchestrate an observing assemblage
- Secure and shape the way the observers described what they saw
- Create a spectacle of science by upgrading common-sense explanations.

Elsewhere I have explored the application of these ideas to the breadth of the physiotherapy education I observed for this study (Kell and Horlick-Jones in press). Here, and throughout this chapter, I will draw attention to aspects of the PEds’ practice that exemplify Lynch and Macbeth’s ideas in the MSk context. Thus the extracts in Figures 5.1 and 5.2 could be described as illustrating the PEds’ ‘positioning’ of their students into the mind-set of a physiotherapist. Once the PEd had ensured that the students were ‘thinking like physiotherapists’, the students were sent away to fetch their patients.

The field note extracts also illustrate how PEds manage the learning of two students simultaneously. In both Figures 5.1 and 5.2 the PEds appear to be conducting two individual preparatory activities but the data suggest that the students are interacting differently with their PEd. In Figure 5.1 Line 2, Louise responds first to Caroline’s offer of help and the PEd’s attention is focussed on her with only brief inclusion of the other student (Lines 6-7). Louise’s quick response is perhaps a learnt interaction practice to ensure she gets quickly to her patient whom she knows is waiting.

iii) The early phases of an MSk new patient assessment

By observing the broad practice of the department I learnt that patients reported to the departmental administrator at the office ‘hatch’ on arrival. The administrator scrolled through the online departmental diary and placed a tick by the name of the patient. In this way the students (and their PEds) could see, from the Treatment Room computer, when their patients had arrived. Due to consent issues (discussed in Chapter 3) I was not able to accompany the students as they made their first introductions to the patients in the waiting area. Therefore my field notes record student: patient interactions from the moment the student (always leading the way) appeared around the corner of the curtained cubicle they were planning to use, and closed it behind the patient.
a. Student: patient spatial orientation

Figure 5.3 illustrates the typical cubicle physical orientation of patient and student interactions during 4 of my 6 days in the field. Patients consistently, and without being asked, went to sit on the cubicle’s one chair while the student sat on the plinth.

Figure 5.3: The interaction spatial orientation at the start of a MSk assessment

As illustrated in Figure 5.3a, Emily always sat on the plinth at whatever height from the floor she found it, and Louise (Figure 5.3b) always lowered it so that her feet rested on the floor. While Amy (Emily’s PEd) did not observe her patient-facing interactions, Caroline often observed Louise (sitting like me on a stool to one side of the interaction) and made no comment about her use of space in the cubicle. For two observation days however, spatial arrangements were different as illustrated in Figure 5.4.

Figure 5.4: Belinda’s cubicle layout. Belinda is sitting behind one plinth watching the interaction between Gareth (with the notes) and his new patient.
The use of space in Figure 5.4 is noticeably different from that in Figure 5.3. In Figure 5.4 two cubicle areas have been converted into one space by drawing only the external curtains. As such there are two plinths and two chairs in the ‘room’. The two plinths in the space have not been moved from their normal location so Belinda is resting on one and the other is behind Gareth. When I asked Gareth why he set the space up like this he said that he was following what Belinda (their Band 7 PEd) had done on their first morning (the only time students’ observed their PEds with patients in core work interactions).

b. Preliminary clarifications and setting the parameters of the interaction

Whatever the spatial arrangement, it is clear from Figures 5.3 and 5.4 that there is a sense of expectation between the interaction players. In all three proxemics sketches the patients appear to be perching on the edge of their chairs, and at least in Figure 5.3b, eye contact has been established. Figure 5.5 presents the first minute of verbal communication between the three students’ and their new patients. Each verbal exchange immediately followed the physical seating of student and patient.

Figure 5.5: Three examples of early verbal communication in MSk physiotherapy interactions.

<table>
<thead>
<tr>
<th>Example 1: Emily and patient: 9.30 am</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emily sits perched on plinth. Patient strokes her shoulder</td>
</tr>
<tr>
<td>2. Emily checks personal details</td>
</tr>
<tr>
<td>3. Emily: ‘OK we have a referral from Dr B that you have a shoulder problem. Could you tell me what has been going on?’</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 2: Gareth and patient: 9.34 am</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Gareth to patient: ‘What would you like me to call you?’</td>
</tr>
<tr>
<td>7. Settles patient in chair opposite him. Pt anxious, going up and down on heels.</td>
</tr>
<tr>
<td>8. Gareth clarifies contact details.</td>
</tr>
<tr>
<td>9. Gareth to pt: ‘You’ve been referred for pain in your left shoulder. What has been going on?’</td>
</tr>
<tr>
<td>10.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example 3: Louise and patient: 9.43 am</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Pt taking off coat while Louise lowering bed and standing waiting;</td>
</tr>
<tr>
<td>12. Pt: ‘Sorry’ and sits in chair</td>
</tr>
<tr>
<td>13. Louise: ‘If it’s OK, can we check a few details?</td>
</tr>
<tr>
<td>14. Pt clarifies</td>
</tr>
<tr>
<td>15. Louise: ‘So, when did you first get your new problems?’</td>
</tr>
</tbody>
</table>

Analysing the early verbal exchanges between students and patients in Figure 5.5 suggests that the pair do not engage in phatic talk. Indeed the recording of a patient’s ‘Sorry’ response in Example 3 Line 11 suggests that, until that point, there had been no verbal interaction.
between the student and patient since they entered the cubicle (although this was masked by continuous background noise from a nearby radio). Malinowski introduced the term ‘phatic communication’ in 1923 to describe the elements of verbal interactions that appear to have little purpose when taken literally, but which, in the context of an interaction, serve a specific purpose. Maynard and Hudak draw on Malinowski’s work in their study of patient: doctor interactions (Maynard and Hudak 2008). Maynard and Hudak describe doctors’ use of phatic communication at the start of a therapeutic interaction as creating the verbal space for patient and doctor to physically settle and orientate themselves towards each other. Burnard explored the place of phatic communication in mental health patient: nurse interactions and suggests that phatic or small talk can act both as ‘the lubricant in a conversation’ (Burnard 2003, p. 681) and as a distraction to the progression of the interaction to its main business: the therapeutic interview. Burnard suggests that the nurse is in a powerful place as the instigator of a therapeutic interaction to determine how she uses phatic talk herself (perhaps to put the patient at ease in the interaction) or how she may choose to ignore the attempts at phatic talk from her patient (Burnard 2003).

In my data, perhaps because the patient and student have spoken to each other in the waiting area and walked one behind the other to the treatment room, there is little talk associated with the proxemics sketches in Figures 5.3 and 5.4. Combining verbal and movement-based data sets in Figures 5.3, 5.4 and 5.5 illustrates how ‘the vocal and visual are packaged together to accomplish a particular activity’ (Heath 1986, p. 17). Considering the three Figures as sequences in an interaction, the patients and students can be seen establishing a physical ‘co-presence’ (Heath 1986, p. 33). Without the use of speech the students, however spatially orientated to the patients, are able, through their movements and the prominence perhaps of the patients’ therapy card, to create ‘the environment of expectation that a particular party [here the patient] is responsive for the next activity’ [here the students commencing the subjective phase of the assessment] (p. 34). Louise’s patient’s eye focus movements (Figure 5.3b) are the telling nonverbal communication device here. By shifting her eyes repeatedly from the notes that Louise holds, to Louise’s face while sitting forward in her chair, the patient is demonstrating Heath’s observation that ‘gaze realignment’ (p. 35) is the first move in the transition from small talk to the business of a therapeutic interaction. Through her nonverbal communication Louise’s patient is demonstrating that she is reproducing the behaviour necessary for her to fulfil her ‘momentary categorical membership’ as a patient in the interaction (Heath 1986, p. 48).

Thus, while there is undoubtedly no small talk recorded between students and patients in the early phase of their interactions here, I suggest that this is not intended to be rude. The
iv) The subjective assessment

This section explores how students perform the subjective phase of a new MSk patient assessment. As discussed previously, students at this site conducted their patient-facing interactions either alone or under the supervision of their PEds. At no time during my observation did an MSk PEd interrupt the flow of their student’s subjective assessment. Readers will remember that this differs from the interactions experienced by neuro students at this stage of an assessment. In the neuro setting the PEds were physically close to the students and patient, and frequently interrupted the students to ask patients extended questions themselves. In Chapter 2 I discussed this learning by ‘working with’ more senior practitioners as a feature of a situated learning environment (Lave and Wenger 1991) and suggested that this learning environment enabled students to see and practise ‘doing being operationally ordinary’ (Sacks 1984, p. 419). In the MSk setting students have very little opportunity to observe their PEds interacting directly with patients, but learn the locally acceptable forms of interactional practice through the feedback their PEds do (and don’t) give them on their performances. In this section I draw attention to the situated learning features of the MSk placement to make visible the explicit (i.e. the things that the PEds discuss) and implicit (i.e. the students’ practices that are not discussed) learning opportunities that arise here.

As described elsewhere, the subjective phase of an assessment is a dialogue-based interaction where, through the asking of questions, the therapist gathers information about
the patient’s interpretation of their physical problem. As observed in the neuro outpatient setting, therapists use the patient’s verbal responses to help them scope the focus and scale of the physiotherapy-related problems from the patient’s answers. The therapist’s ideas about the work of physiotherapy identified through this process inform the direction of the physical, or objective assessment, which follows.

Analysing the data suggests that four specific features of the MSk setting impact on the students’ conduct of a subjective assessment. Firstly, students have only a short, and often handwritten, referral to guide their early interview questioning. Secondly neither the PEd nor the student have had anything to do with booking the patient’s appointment and thus would not have spoken to them in advance of the assessment. Thirdly, the MSk students know that they are working within a set time frame. And finally, the students will be aware that they will be taken away from the patient at the end of this interaction to ‘reason through’ their patient. In the discussions that follow I will explore the impact of these organisational features of the MSk placements on patient: student interactions.

a. Setting the boundaries for the verbal interaction

The field note extracts in Figure 5.5 illustrate the typical way that students made the transition from the orientation- to the first information gathering- phases of the assessment interaction. In Lines 4 and 14 the students narrow down the potential interaction discussion topics by their articulation of the body part that was the focus of the referral. Through their simple turn of phrase the students both mark the transition to the subjective assessment and direct their patient’s attention towards the body part in question. Thus when the student asks their first formal question (e.g. ‘So what has been going on?’) the patient is expected to know the parameters in which a response is to be framed.

Figures 5.6 and 5.7 record the field notes of two student-led subjective assessments. As discussed above, the students have limited time in which to collect the verbal information from their patients that will enable them to clinically reason the patient with their PEd. In this section I explore the data to illustrate two different ways that students control the direction and pace of their patients’ responses.
Figure 5.6: Gareth’s typical approach to the subjective phase of a new patient assessment

1 9.34 am
2 Subjective assessment begins.
3 Gareth clarifies contact details.
4 Gareth to pt: ‘You’ve been referred for pain in your left shoulder. What has been going on?’
5 Pt launches off into very fast, non-stop story. Gareth writes, stops, watches patient. After a
6 while patient pauses. Gareth: ‘I'll take one at a time. So you went to the GP for anti-
7 inflammatories?’ writes. Patient answers question and stops, looks at notes.
8 Gareth: ‘So when are you getting this pain in your shoulder?’

9.37 am

<table>
<thead>
<tr>
<th>9.37 am</th>
<th>Looking at shoulder____</th>
<th>Starts notes writes</th>
<th>eye contact</th>
<th>eyes writes</th>
<th>eyes</th>
<th>Face then notes____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gareth</td>
<td>Asks qu interrupts;</td>
<td>notes</td>
<td>asks another qu: 'OK so..'</td>
<td>still listening</td>
<td>notes asks qu</td>
<td>Asks qu, then writes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient</th>
<th>Looks face</th>
<th>Looks at notes</th>
<th>looking at floor in front</th>
<th>silent</th>
<th>Responds____________________</th>
<th>responds</th>
<th>Replies then silent watching notes ______</th>
</tr>
</thead>
</table>

9 9.41 am
10 Subjective assessment on-going. Plenty of eye contact while Gareth asking questions,
11 listens as patient responds and writes when nearly done.
12 Gareth: ‘Just a few general questions now.’
13 Completes past medical and drug history;
14 Discuss occupation and demands of work and sport. Pt shows Gareth the type of movement
15 he has to do at work (Sketch below, Gareth on right)

16 Plenty of eye contact re loads for work, lifting frequency.
17 Gareth: ‘Tell me about your home life – how old are your grandchildren, do you need to carry
18 them much?’
19 Gareth makes notes, pt silent and watches notes being written.
20 Gareth turns notes to pt to check that he has recorded location of pain accurately (Sketch
21 overleaf).
Gareth: ‘OK that is all I need to ask you. We will just pop out and have a chat.’

We leave.

Figures 5.6 and 5.7 comprise three different forms of data collection that work together to illustrate the verbal, kinesics and proxemics elements of the observed interactions. The multi-faceted records of the student: patient interactions illustrate two methods by which students control the type and speed of their patients’ responses and exemplify Lynch and Macbeth’s notion of ‘disciplining witnesses’ in the physiotherapy context (1998). Firstly both students appear to be asking questions in a pre-determined order. In Figure 5.6 Gareth asks the patient to frame the reason for his referral in his own words (Lines 4-5). Having established that ‘pain’ is the likely physiotherapeutically-relevant element of the patient’s response (Line 8), Gareth focusses his questions (here in the text of the kinesics stave) to explore the location, severity and other descriptors of that pain. Gareth’s reference in Line 12 to ‘a few general questions’ foregrounds a change in the direction of the questions towards the pain in context i.e. its coexistence with other factors in the patient’s life, for example medical, work and family activities. The consistent student activity, accompanying each step of the verbal interaction in Figure 5.6, is the creation of written notes. Before closing the subjective assessment in Line 22, Gareth asks the patient to verify the transformation he has made of the patient’s pain onto a pre-printed body chart. Figure 5.7 illustrates a similar sequencing of questions in Louise’s subjective assessment of her new knee patient. Like Gareth, Louise seems to focus on the patient’s pain.

The field notes in Figure 5.7 Lines 3-31 illustrate Louise’s efforts to get her patient to describe his pain in words that she can account for. Her short questions in Lines 3-9 suggest that the patient is neither providing the information that Louise feels she needs nor quantifying his pain using her numerical parameters. Only when Louise appears satisfied
that she has scoped the physiotherapy case for this patient’s pain does she move the interview on to follow the ‘general questions’ pattern seen in Figure 5.6.

Figure 5.7: Fieldnote extract of the subjective phase of Louise’s new patient assessment

110

Louise’s interaction with her patient is particularly interesting because, in Figure 5.7 Line 20, her patient offers a new symptom related to his knee condition that may or may not have anything to do with the pain that has been the focus of the conversation so far. This
spontaneous interjection by a patient is unique in my data set. Lines 21-29 illustrate Louise repeating her earlier step-wise clarifications of this new symptom before she draws this phase of the interaction to a close.

The second strategy for controlling patient interactions during a subjective assessment is illustrated in the kinesics staves in Figures 5.6 and 5.7. Unlike the neuro new patient assessments, the participants in MSk subjective assessments were physically well and could sit without physical support from the therapist. In these non-contact interaction sequences it was possible for me to concentrate on recording the nonverbal communicative practices accompanying the participants’ spoken words using kinesics staves. Described in Chapter 3 and elsewhere (Kell 2011), the creation of kinesics staves builds on Heath’s ideas for recording coexistent verbal and visual communicative actions (1986). The kinesics staves developed for use in this study are unique in their ability to capture snippets of interaction kinesics in real time and have been developed to focus specifically on participants’ gaze-based interactions. The kinesics staves are read from left to right and map the students’ kinesics against those of their patients. The kinesics staves in Figures 5.6 and 5.7 illustrate students’ control over the direction and flow of patient talk through their giving and removing of eye contact to their patient.

In Figure 5.6 Gareth uses the removal of his eye contact and the refocusing of his attention on the notes he is writing to stop his patient talking. At the start of this phase of the assessment the field notes record the patient’s hurried narrative. Having given the patient full eye contact (Line 6), Gareth stops the patient and, initially through his careful breakdown of the questions he asks (Lines 6-8) and then through the use of eye contact, controls the patient’s narrative so that he can make appropriate notes. Louise in Figure 5.7 appears to be having the opposite challenge with her patient. Her patient is presenting after a knee operation that would have been preceded by earlier episodes of physiotherapy. Perhaps because the patient is used to the expectations of physiotherapy subjective assessments, Louise is having difficulty getting a narrative from him. At the start of the kinesics stave we see the patient pause in his response as soon as Louise withdraws her eye contact and begin to write her notes. As the interaction progresses, Louise uses shorter questions with associated flickers of eye contact to encourage the patient to continue responding. While, as with Gareth’s assessment, eye contact interaction is the tool for driving the flow of the interaction here, it is interesting to note that it may well be the patient who is ‘disciplining’ Louise.
This section has illustrated consistent approaches to the way students conduct MSk subjective assessments. Students appear to direct and control the extent and content of their patients’ narratives through their use of question structure and kinesics. This focus and control demonstrates the ‘taking’ rather than the ‘receiving’ of a patient’s history described by Gale in her observation of similar assessment phases in osteopathy practice (Gale 2011, p. 242). Throughout the subjective assessments discussed here there is a sense that the interview is being conducted for a distinct purpose. From the access interview with Megan and Naomi I knew that the students were about to be debriefed by their PEd and needed to be able to make their own verbal account of the case for physiotherapy intervention they had identified from their patient’s story. The students’ awareness of the discussions that were to follow might account both for the control of the interaction they adopted and the near absence of questions that would enable the patient to direct the conversation to their own needs. While Louise did ask her patient ‘So what is your main goal from physiotherapy?’ (Figure 5.7 Line 30), her language use suggests that she was not thinking about this interaction from the patient’s perspective and how he might understand what she was asking.

The students’ final sentences in both subjective assessment extracts sum up the intentions that have implicitly underpinned their preceding patient interaction. In Figure 5.6 Line 22 Gareth alludes to an externally imposed framework by his comment ‘That is all I need to ask you.’ With no further explanation to their patients, Gareth and Louise signal the transition to the next phase of the assessment by telling the patients that they are going ‘to talk with my senior’ (Figure 5.7 Line 31). Each subjective assessment I observed ended with this type of statement and the students, usually deep in thought, standing up, taking their notes and leaving the cubicle.

b. Moving to the PEd-led debrief phase

The PEd-led debriefs that followed each subjective assessment usually took place standing or sitting in an open therapy area set apart from the Treatment Room. When this space was occupied the PEds took the students to their desk area (which could be in ear shot of the patient). Analysing all the students’ patient-facing activities suggested that their physical movement between the patient present and patient absent phases of the MSk assessment played an important role in the progression of the assessment as a whole for two reasons. Firstly the time the students took to complete the subjective assessment impacted on whether they could progress directly to the PEd-led debrief or be made to wait. All students took 15-19 minutes to perform the assessment, but, within the departmental placement
structure, it was only possible for the PEd to debrief one student at a time. Each student told me that because both students would be finishing their first phase interactions at roughly the same time it was important to try to be the first student to locate the PEd (if they had not been observing the interaction) and start the debrief. If the PEd was busy with one student, the second had to wait, while of course their patient also waited. Observing the task-focused nature of the students’ interactions and being aware of their perceived time pressures resonates with Trede and Higgs’ finding that therapists are unlikely to adopt a narrative approach to patient interaction and clinical reasoning where they perceive time and caseload pressures (Trede and Higgs 2008).

The second impact on the assessment of the students’ physical removal from their patient for the debrief is precisely that they have left their patient behind. Not only is the patient left waiting for their return having been given little indication of the reasons for the student’s absence, but the notes the student has made about them and not they themselves become the focus of the PEd debrief. This apparent translation of a person into a paper record is reminiscent of Latour’s work describing how the writing of laboratory science reports is done. In his paper Latour reports that he

‘was struck… by the way in which many aspects of laboratory practice could be ordered by looking not at the scientists brains (I was forbidden access!), nor at the cognitive structures (nothing special), nor at the paradigms (the same for thirty years), but at the transformation of rats and chemicals into paper’ (1990, pp. 21-22).

Latour’s observation resonates powerfully with the scenes of students walking away from cubicles carrying only their patient notes. Latour recognised that, in the act of making notes, the scientists he observed were ‘anchoring’ their science in a way that was ‘mobile, presentable and readable’ (p. 26). Latour suggested that the note making process, the act of writing things down so that ‘things that were far away could unfold in front of your eyes’, created a connection between the observers of that written text, and also transformed seemingly insignificant data into ‘the only significant aspect of reality’ (1990, p. 60). Coining the term ‘immutable mobiles’ (p. 23) Latour explored both the ‘logistics’ of the way these written artefacts were created and the power they inherently possessed (through their mobility / portability and stability) to emphasise the ‘balance of forces between those who master [here the students] and those who are mastered [here the patients]’ (1987, p. 227).

Recognising that, by the time I observed the students, they had had many previous debriefs with various PEds, we can assume that the data collected during the subjective assessment discussed above illustrates the practice of students anticipating a specific form of debrief.
Thus whether the debrief drives the structure of the subjective assessment, or whether the culture creates this subjective assessment practice and thus leads to a certain form of debrief is impossible to unpack from the data in this study. Whatever the 'cause', the practice of removing the student from the patient for a debrief implicitly changes the role of the patient from a person with a problem that a physiotherapist could help, to a case to be appropriately inscribed onto paper for therapists to consider as relevant to their work.

v) The post-subjective assessment debrief

Analysis of all the post-subjective PEd: student debrief interactions observed in this study suggest that:
- the student-created notes are the main artefact in the interaction,
- the debriefs follow a similar pattern,
- the PEds use similar language and that
- the debriefs are powerful situated learning experiences.

This section will explore each of these elements in turn.

a. Participant orientation to the notes

The proxemics sketches in Figure 5.8 record the typical physical arrangement of debrief interactions. In Figure 5.8 both sketches illustrate participants whose body postures suggest they are turned towards each other. The notes the student has made from the patient's subjective assessment are held (Figure 5.8a) or lie (Figure 5.8b) between the PEd and student. Tracking eye gaze (hashed lines) and the arm movements of the PEds suggests that the notes provide a visual and physical focus for the verbal elements of the interaction. The centrality of notes suggests that they are 'anchoring' the now distant patient so that the 'significant aspects' of their reality can 'unfold' from a page in an expected order (Latour 1990, p. 26).

The proxemics sketches in Figure 5.8 also resonate with another ethnomethodological study of the work of scientists. Amann and Knorr Cetina explored the practical accomplishment of scientists developing and reading DNA screening films (1990). The researchers describe the following three steps by which the scientists they observed created and justified their work:
- Enhancement – the making visible of the science
- Inspection of the data by others
- The transformation of the data into evidence (p. 88)
This sequential process of ‘creating science’ translates directly into the practices of physiotherapy education being discussed here. ‘The making visible’ of the data, and the students’ selection and focusing practices that lead them to identify patient responses as data worthy of being recorded, has been discussed earlier in the exploration of the process of note writing. Here, at the start of the debrief, we are seeing PEds and students commencing step two of the sequence. In Figure 5.8 the notes could be described as being ‘the machinery of seeing’ as the interaction participants ‘gather around the visual materials, finger the documents and gaze about their surfaces’ with their actions ‘embedded in talk’ (Amann and Knorr Cetina 1990, p. 90).

b. Interaction sequencing and language use

By sitting to one side of the debriefs I was able to record the ‘talk’ or verbal elements of the pair’s interactions quite comprehensively as illustrated in Figure 5.9. Whether or not the PEd had observed the subjective assessment, the verbal interaction always commenced with the PEd asking the student for their early thoughts on the data they had collected. Figure 5.9 Line 1 is unusual in that Caroline starts the dialogue with a snippet of feedback on Louise’s subjective assessment performance. This was the only example of feedback recorded in my data. The absence of such feedback from PEds, regardless of grade and seniority, suggests
that the students’ use of language, kinesics and proxemics in their patient-facing interactions were unremarkable and expected. The consistent immediate focusing on the data rather than the process of its collection implicitly endorses to the students that the former was the main purpose of their 15 minute patient interview.

Figure 5.9: The verbal elements of Caroline’s subjective debrief with the student Louise (text in red to be explored later in this section).

<table>
<thead>
<tr>
<th>10 am In gym on plinth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline: ‘So nice assessment. What would you say about the severity of his symptoms?’</td>
</tr>
<tr>
<td>Louise: ‘Moderate.’</td>
</tr>
<tr>
<td>Caroline: ‘Why?’</td>
</tr>
<tr>
<td>Louise offers</td>
</tr>
<tr>
<td>Caroline: ‘Seems logical, so what about irritability?’</td>
</tr>
<tr>
<td>Louise responds</td>
</tr>
<tr>
<td>Caroline: ‘OK, um I’d probably put it more towards low level, so what about pain mechanisms? What do you think?’</td>
</tr>
<tr>
<td>Louise responds</td>
</tr>
<tr>
<td>Caroline expands: ‘What did he say that made you think…?’</td>
</tr>
<tr>
<td>Louise responds</td>
</tr>
<tr>
<td>Caroline: ‘There is one… So the fact that he doesn’t like…? So I agree with you, there is inflammation, any other pain mechanisms?’</td>
</tr>
<tr>
<td>Louise responds</td>
</tr>
<tr>
<td>Caroline: ‘Yes but you could have asked about… but to be honest what you did was fine.’</td>
</tr>
<tr>
<td>Louise offers</td>
</tr>
<tr>
<td>Caroline: ‘So what could you have asked to ascertain…?’</td>
</tr>
<tr>
<td>10.06 John (student 2) appears and loiters</td>
</tr>
<tr>
<td>Caroline: ‘So we are definitely thinking… we are not completely sure about… anything else from social that you think…?’</td>
</tr>
<tr>
<td>Louise: ‘Well the yellow flag about his job.’</td>
</tr>
<tr>
<td>Caroline: ‘Yes but he had lots of friends who have had this so just keep in the back of your mind. So what are you going to look at today?’</td>
</tr>
<tr>
<td>Louise: ‘Posture’</td>
</tr>
<tr>
<td>Caroline: ‘Before that, anything else?’</td>
</tr>
<tr>
<td>Louise: ‘Palpation?’</td>
</tr>
<tr>
<td>Caroline smiles and expands</td>
</tr>
<tr>
<td>Caroline: ‘So you are going to look at posture.’</td>
</tr>
<tr>
<td>Louise: ‘Yes and gait.’</td>
</tr>
<tr>
<td>Caroline: ‘Any other function?’</td>
</tr>
<tr>
<td>Louise: ‘Sit to stand.’</td>
</tr>
<tr>
<td>Caroline leans forward, meets Louise’s eyes: ‘Yes, but anything else he mentioned…. Like the stairs?’</td>
</tr>
<tr>
<td>Louise: ‘Oh yes.’</td>
</tr>
<tr>
<td>Caroline: ‘So while he is in here do all that… so if you go in and start the objective, I shall speak to John.’ 10.12 am</td>
</tr>
</tbody>
</table>

Figure 5.9 illustrates two consistent features of debrief interactions: a first exploration or verbal sense making of the data the student has collected (Lines 1-22), and a second phase in which the PEd helps the student to use the thoughts generated by the data discussions to inform the planning of the physical (or objective) phase of the assessment that follows the
debrief (Lines 22-35). Lines 1-11 show Caroline testing the student’s understanding of the data they have collected in terms of ‘physiotherapy’. Caroline’s opening question in Line 1 does not ask Louise to recount her findings, but rather launches straight into testing her understanding of the relevance of the patient’s words as indicators that there is a case for physiotherapy here. Through her choice of words that seem to have specific meaning in this context (e.g. ‘irritability’ Line 5) Caroline takes Louise through a step-wise thinking process. At each step Louise is asked what she thinks before Caroline either asks her why she made that deduction (the usual response when a student’s answer appeared not to be what the PEd wanted), or offers her own thoughts and expands these further (the typical response when the student is perceived to have responded appropriately). Notably in Figure 5.9 Lines 10, 12 and 15 Caroline makes reference to her assessment of the patient’s responses and is able to talk Louise through her own decision-making process. This sharing of personal thinking practice was an important feature of the debriefs conducted by PEds who had observed the full subjective assessment.

Six minutes into Louise’s debrief (Line 18) her fellow student John appears and waits for his debrief to commence. Because Caroline observed Louise’s subjective assessment she would not be able to conduct John’s debrief in the same way or offer him insights into her own thinking practices. Figure 5.10 records the typical format and dialogue of the first phase of a debrief where the PEd (here Amy) had not observed the student with their patient. In Figure 5.10 Amy must rely on the accuracy of Emily’s record-making, and her verbal interpretation of it, to both get a sense of the patient case from which the data was generated, and ensure that, in the second phase of the debrief, she guides appropriately Emily’s selection of physical assessment tasks.

Figure 5.10: The first phase of a subjective assessment debrief when the patient-facing assessment had not been observed by a PEd (here Amy)

| 1 | Day 2 9.45 am Amy standing by sink: ‘So how was that?’ |
| 2 | Emily reports, Amy looking at body chart asking a few clarifying qus, Emily continues; |
| 3 | Amy: ‘So start with the SIN factors – how would you rate this…’ |
| 4 | Emily expands: ‘I would say moderate…’ |
| 5 | Amy agrees and expands further: ‘How about irritability?’ |
| 6 | Emily responds; |
| 7 | Amy: ‘Think about our pain mechanisms, what would you say…?’ |
| 8 | Emily: ‘Mechanical.’ |
| 9 | Amy off speaking very fast… ‘Do you think it is inflammatory?’ |
| 10 | Emily: ‘No, no 24-hour pattern’ |
| 11 | Amy races away… ‘So definitely not inflammatory… So I think there is evidence of that, so that is the first place I’d go – so what can we do to clear that?’ |
The second phase of the debrief starts when the PEd refocuses the dialogue. In Figure 5.9 Line 23 Caroline marks the transition with the question ‘So what are you going to look at today?’. The objective phase of a physiotherapy assessment involves the therapist looking at, feeling and trying to quantify elements of a patient’s physical performance. Thus to a student the phrase ‘to look at’ would sum up the intentions of the objective assessment.

Figure 5.9 Lines 24-35 suggest that there is a standard framework for an objective assessment. In Line 25 we hear Caroline correcting Louise’s attempts at verbalising how she will structure the assessment and then guiding her planning for the rest of the interaction. Each Band 6 PEd I observed followed the task-focussed pattern illustrated by Caroline here.

Figure 5.11 illustrates Belinda’s approach to the second phase of the debrief which, perhaps reflecting her greater experience in the MSk speciality, is different from that of her colleagues as she helps Gareth attach elements of the planned objective assessment to specific ‘diagnoses’ they want to test. In Line 4 for example, Belinda draws Gareth’s thinking down onto the specific objective tests. Thus, rather than using broad terms like ‘look at posture’ (Caroline Figure 5.9 Line 28), Belinda and Gareth discuss a specific test that she thinks is particularly relevant to their patient. In Figure 5.11 Belinda can be seen physically demonstrating the test on Gareth’s bare foot. This specific teaching of a skill during a debrief was unique in my data set.

Figure 5.11: An experienced PEd teaching patient-specific objective assessment skills

1 Day 5 2.00 p.m.  
2 Belinda: ‘So planning the objective then, we have quite a few possible diagnoses.’  
3 Gareth: ‘I have to clear neuro.’  
4 Belinda: ‘So if we go with her main pain here, what do you think?’  
5 Gareth offers++  
6 Belinda: ‘Yeah, good’ eye contact ++, flashes back and fore to notes ‘yeah.’  
7 Gareth: ‘Can you do the valgus varus test?’  
8 Belinda and Gareth move their ankles as Gareth speaks, then Belinda hops off bed to point at her foot in standing: ‘Do you want me to show you?’ (Sketch below)

10 Gareth takes his shoe and sock off, puts his foot on plinth for Belinda.  
11 Gareth puts S+S back on and goes back to pt.
c. The work being done by the away-from-patient debrief

Each subjective assessment debrief lasted between 7 and 9 minutes and helped the PEds achieve one of their key placement learning aims: the development of students’ clinical reasoning skills. Throughout the field note extracts in Figures 5.9-11 the PEds frame their questions and develop students’ responses using shared and physiotherapy-specific language to ‘secure and shape the way the [students] described what they saw’ (Lynch and Macbeth 1998, p. 277). In this way the PEds could be described as ‘disciplining witnesses’ in the sense that the students are witnesses who must affirm and adopt the expected thinking and reasoning practices of their social group. Both the patient-as-an-abstract and the step-wise approach to clinical reasoning suggest that the PEds are teaching their students to account for their practice by adopting a hypothetico-deductive model of reasoning (Garfinkel 1974b; Trede and Higgs 2008).

But more than this, the data suggest practice underpinned by a discourse of science. Each Figure in this section illustrates the PE ds and students physically and verbally manipulating the notes to ‘transform data into evidence’ and create the case for the patient’s need of physiotherapy (Amann and Knorr Cetina 1990, p. 88). By combining verbal and visual data we see the PE ds and students reach ‘agreement that there are questions that must be asked’ to confirm their ideas and test hypotheses in the objective phase of the assessment (Amann and Knorr Cetina 1990, p. 94).

This process of reaching agreement, or at least the PEd gaining verbal agreement for her ideas from her student, is perhaps the most powerful learning experience in these interactions. In Figures 5.9-11 key words have been highlighted in red. These words track visually the changing personal pronouns that the PE ds used with their students. Getting behind the physiotherapy / science language of the interaction suggests a pattern of personal pronoun use. In each interaction the PEd first seeks the student’s opinion and then locates the response in the context of their own thinking. Having demonstrated thinking agreement, the PE ds then consistently close the first phase of the debrief using language that suggests a shared understanding. The use of the word ‘we’ is a powerful endorsement to the students of their legitimate peripheral participation in this community of physiotherapy practice (Lave and Wenger 1991). By seeming to accept the students’ ideas into their own thinking frameworks, and in Gareth’s case being physically handled (Figure 5.11 Sketch), the PE ds are demonstrating the students’ movement towards ‘participation in the sociocultural practice of [their] community’ (p. 29). Once the students have received this affirmation they are further accepted into the community of physiotherapy by being allowed
to go, often on their own, to physically touch and move the patient. These short debrief interaction sequences are powerful demonstrations of a ‘master’s effectiveness’ in their ability ‘to manage their apprentice’s [here student’s] performance in congruent ways to provide participatory opportunities for student growth’ (Lave and Wenger 1991, p. 21).

vi) The Objective Assessment

During the objective phase of an assessment the therapist undertakes a physical examination of the patient. Therapists focus their examination on body parts and forms of data that help them test out their ideas about the possible physiotherapy-relevant causes underpinning the patient’s presenting problems. As we saw in the PEd-led subjective assessment debriefs, there is a set order in which an objective assessment is conducted. Despite only one PEd being able to observe fully one student’s assessment during my study (the other PEds were always busy with the second student), the students performed remarkably similar activities. Each objective assessment could be broken down into three phases: an observation phase, a general testing and measurement phase and a final ‘special tests’ phase. In this section I illustrate the performance of these phases and discuss how the term ‘objective’ assessment appropriately reflects both the forms of data the students are trying to collect and the role the patient has to play in the interaction.

   a. Observing the part

At the start of an objective assessment the students observe the affected body part for visible signs arising from the patient’s physical problems. The patient must remove any clothing that is covering the body part to enable it to be observed. Figure 5.12 collates three field note extracts that record students’ immediate words and actions when they return to their patient’s cubicle following their subjective assessment debrief. The extracts have been selected because they record undressing practices for three different body parts.

Figure 5.12: Typical methods for getting the patient to expose their body part

<table>
<thead>
<tr>
<th>extraction</th>
<th>description</th>
</tr>
</thead>
</table>
| a) Emily’s 65 year-old female patient has been referred for neck pain | 1 Back in cubicle with pt.  
2 Emily: ‘I’d now like to look at your posture. So would you mind slipping off your top?’  
3 Leaves patient to make sure curtain closed completely. |
| b) Gareth’s 56 year-old male patient has been referred for shoulder pain | 4 Back in cubicle with pt.  
5 Gareth: ‘Are you OK to take your top off? I will be writing notes as we go.’ |
Gareth turns away from patient and rests notes and pen on the plinth.
Pt takes off t-shirt, has vest on underneath – leaves this on.
Gareth: ‘Right turn your thumbs to the front and raise them up. Tell me about the pain.’

Louise’s elderly male patient has had a partial knee replacement.

10.12 Back with patient
Louise to pt: ‘So to start with I need to have a look.’ Kneels on floor by pt and asks about his
calf pain (Sketch below: notes on plinth between them).

Pt: ‘I don’t think these (trousers) will go over (knee). I do have shorts on.’

Takes down trousers.

Louise looks at knee and scar. Pt: ‘My war wounds.’

The field note extracts in Figure 5.12 record students working with two upper body and one lower body patient referrals. In all extracts the students appear through the cubicle curtain and launch into the objective assessment without offering patients a reason for their absence. Further, beyond Emily and Louise’s short statement about their ‘need to have a look’, the patients get no warning about what is to come. The abrupt transition to the physically intimate phase of the assessment was consistent in all cases. Emerson’s study of the practice of medical gynaecological objective assessments (1970) resonates with some practices observed here because, like the physiotherapy students, the doctors she observed arrived to conduct the physical examination on patients who have been waiting for them. While, unlike the physiotherapy patients, the patients in Emerson’s work would have known what they were waiting for, in both her study and the data presented here the final exposure of the part to be assessed has to be negotiated and navigated by the interaction participants in order for the interaction to progress. Emerson uses the expression ‘normal trouble’ (p. 80) to describe the expected challenges to the smooth running of an interaction when that interaction is occurring in ‘precarious’ circumstances (p. 75). Any physical examination could be described as a precarious interaction because it is not normal human interaction practice for one stranger to physically handle the undressed body of another.

Figure 5.12 illustrates physiotherapy students managing the ‘normal trouble’ of a patient interaction in ways that resonate with Emerson’s observations of physical examinations.
The first strategy, captured in Lines 3 and 6, is the practice of ‘disattention’ (p. 76). In Figures 5.12a and b Gareth and Emily momentarily turn away from their patient following the request to remove their clothing. In each case, by the time the student turns back to face their patient, the latter has transformed from individual into body-for-examination. Emerson suggests that this transformation from person into a ‘technical object’ (p. 78) is essential for the physical contact that is to follow. By approaching the patient in a matter-of-fact way the students indicate both that their normal work lies on an ‘assembly line for repairing bodies’ (Emerson 1970, p. 78) and that their imminent actions are credible precisely because of their role in the interaction.

Figure 5.12 also suggests that the location of the affected body part influences the way the students access it and proceed with the physical examination. In Figure 5.12c Louise kneels on the floor in front of the patient ready to observe his knee as he tries to roll up his trouser leg. In contrast once the part is exposed, in both Figures 5.12a and b, instead of conducting a period of careful observation (the first phase of a hypothetico-deductive reasoning based objective assessment; Edwards and Richardson 2008) the students progress immediately to the testing and measuring phase of the assessment. The exclusion of the observation phase during upper body related assessments suggests that students, perhaps less certain of their own ability to act with the confidence demanded of therapists in this precarious interaction situation, progress to the more technical elements of the assessment over which they could be expected to have more expertise than the patient, rather than risk destabilising the ‘normal trouble’ of the encounter through their blushing or similarly inappropriate behaviour (Emerson 1970).

b. Testing and measurement during an objective assessment

The extract of the subjective assessment debrief in Figure 5.11 suggested that the aims of an objective assessment are to collect data, through touch and measurement, by which possible causes of patients’ presenting problems can be eliminated (‘cleared’ Line 3) or focussed on more specifically (Line 7). Figure 5.13 illustrates the typical verbal, kinesics and proxemics elements of this physical data collecting interaction.

Figure 5.13: Collecting and recording ‘objective’ data from a patient.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9.58 am</td>
</tr>
<tr>
<td>2</td>
<td>Back in cubicle with pt.</td>
</tr>
<tr>
<td>3</td>
<td>Gareth: ‘Are you OK to take your top off? I will be writing notes as we go.’</td>
</tr>
<tr>
<td>4</td>
<td>Pt takes off t-shirt, has vest on underneath – leaves this on.</td>
</tr>
<tr>
<td>5</td>
<td>Gareth: ‘Right turn your thumbs to the front and raise them up. Tell me about the pain.’</td>
</tr>
</tbody>
</table>
Gareth does the move himself. Pt follows, Gareth watches.
Pt offers, Gareth clarifies, writes in notes.
Gareth: ‘Turn your thumbs over and raise to the side.’
Gareth measures with goniometer (Sketch 1 below) and writes notes squatting by bed while
pt rubs his shoulder (Sketch 2 below)

Gareth lowering back rest on bed: ‘I am going to lie you down and move your arm like this
(shows pt on their right arm), just keep talking to me about what you are feeling. Let it go
heavy.’
Gareth assesses passive range of shoulder movement and makes notes (sketches below).

Figure 5.13 is the main data set for this discussion of a typical student-led MSk
physiotherapy objective assessment. As illustrated in Lines 6-10 patients were first asked to
move their affected body part through a range of different positions. Having observed and made notes about how the patient performed the movement in both shoulders, Gareth makes an objective measurement of the range through which the patient is able to move his affected shoulder (Line 9 and Sketch 1) using a goniometer or long-armed protractor. The patient must hold his arm steady while the measurement is taken, in this case from behind. After each measurement the student records his findings on his notes (Sketch 2). In all student: patient interactions patients were left to their own devices while the student made their annotations. The patient’s shoulder rubbing and glancing around the cubicle (Sketch 2) were typical activities during this period.

When students were happy that they had collected the information about their patient’s general ability in an upright position, they then focused more specifically on the affected joint. Figure 5.13 Sketch 3 illustrates a significant step in the progression of the objective assessment. By lying the patient down and taking over the physical movement of the patient’s shoulder from him, Gareth is using his hands to assess the possible internal joint restrictions to the movement available. This passive movement phase of an assessment was always conducted in silence. The student's eyes fixed on the patient's face when the limb being moved was upper body (as Sketch 3) and on the part being moved when a lower limb part was being moved. In all cases the patient appeared to be looking past the therapist and focusing their eyes on a point on the ceiling above them (Sketch 3 and Lines 16 and 20) as if ‘attending to the background detail’ (Emerson 1970, p. 86). When each movement was complete the patient’s limb was placed on the plinth and the student went to record his findings. Sketch 4 captures Gareth making his notes squatting by the chair while the patient lies on the bed in silence.

c. Specific testing

Objective assessments usually concluded with the application of manual forces to patients’ problem joints to test out specific elements of joint stability and soft tissue integrity. While PEds could assume that the general sequencing and methods for testing joint movement described above would be known and performed appropriately by all third year students, the specific or ‘special’ tests for each joint were likely to be less well (if at all) practised. Figure 5.14 is the only occasion in my dataset when a PEd was present as the student was performing these ‘special’ tests. Line 2 illustrates Gareth’s use of shared physiotherapy language to draw the PEd into a discussion while simultaneously excluding the patient. With Belinda by his side Gareth is helped to both perform the special skills safely and effectively, but also interpret the reasons for what he is feeling. Throughout the PEd-led discussion the
patient adopts a typical ceiling gaze (Lines 4 and 19) while the therapists study his facial expressions in silence as they apply the test.

Figure 5.14: A student drawing a PEd into the interaction to support skill performance

Gareth turns to Belinda sitting behind the plinth: ‘I could use a pillow here for the height for the AtFl?’
Gareth to pt: ‘Do you mind if I talk about you to Belinda?’
Pt: ‘No go ahead’ looks to ceiling.
Belinda comes over. Gareth: ‘I can feel here.’
Belinda: ‘Is it where PFL comes in?’
Gareth: ‘I don’t know, let me double check. Would you like to have a look and get a feel?’
Belinda comes over, feels ankle; chats quietly to Gareth (can’t hear or see much from behind her)
Gareth: ‘So are you alright if we just talk it through?’
Gareth performs stress test (Sketch below) with.
Belinda chatting through what it could be that he is feeling. : ‘So if you try... to clarify that.’
Gareth performs back down
2.22pm Gareth performing stretch, looks at pt’s face: foot: face: Belinda;
Belinda comes over;
Gareth to Belinda: ‘Do I need to fix?’
Belinda and Gareth both watch pt’s face as he puts on the stretch;
Gareth to pt: ‘So if I ease off that.’ To Belinda: ‘So that is ruling out peroneals.’
Gareth and Belinda discussing and looking at foot (Sketch below). Pt looking at ceiling.
Gareth in contact with pt’s foot at all time.
d. Signalling the end of the objective assessment

When the students have collected the objective data they think will be relevant to their imminent away-from-patient post-objective debrief, they draw the assessment to a close. Figure 5.15 collates the closing sequences of the objective assessments for each of the patient interactions in Figure 5.12. The ‘terminal exchanges’ (Schegloff and Sacks 1974, p. 238) for this phase of the assessment are short and controlled by the students. Unlike the socially-orientated interactions described by Schegloff and Sacks however, the patients here are informed that the interaction is about to stop (temporarily) but given no opportunity to contribute additional elements to the verbal interaction and thus delay the closing (1974). As with the end of the subjective assessment phase, the students’ words suggest that their patient has provided the data that is needed for a discussion about them to take place elsewhere. Having completed their data-generating role the patients are not required, or permitted, to offer independent comment.

Figure 5.15 suggests that the temporary participant separation is also starting the process of breaking the interaction participants’ ‘co-presence’ (Heath 1986, p. 129) by beginning the patients’ re-transformation from ‘technical objects’ back into cognisant humans (Emerson 1970). In Figures 5.15a and b Emily and Gareth ask their ‘upper body’ patients to get dressed as they leave the cubicle. In contrast, perhaps because she knows that trousers will limit the movement available to exercise, Louise asks her patient to remain in his shorts (Figure 5.15c).

Figure 5.15: Typical objective assessment closing sequences

<table>
<thead>
<tr>
<th>a) Emily’s closure</th>
<th>b) Gareth’s closure</th>
<th>c) Louise’s closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emily to pt: ‘OK that’s all done. Please could you put your top back on. I’ll just go and chat to my senior’. Leaves</td>
<td>Gareth: ‘Thank you. We are just going to step out again, please put your top back on; we’ll be a few minutes.’ Leave pt.</td>
<td>Caroline back. Louise: ‘OK I have had a look at everything I need for now, so I will just pop out to chat with my supervisor.’ Patient asks if he can change out of shorts. Louise: ‘Just leave for a moment so I can teach you the exercises.’</td>
</tr>
</tbody>
</table>
Section discussion

This section has made visible the verbal, kinesics and proxemics elements of the objective phase of a new patient assessment. Before following the student into their post-objective debrief I want to pause and consider both how the patient and student have worked together to enable a successful objective assessment to be completed, and the opportunities for student learning that arise in this assessment setting.

Exploring the work being done by students and patients during an objective assessment.

From the student’s perspective, a successful outcome from the objective assessment is the creation of a written data set that can be taken away and used in the PEd-led debrief that follows. Here I explore the strategies Gareth practised in Figure 5.13 to collect the best (most objective) data he could from his patient. The strategies Gareth used were typical of those used by all students I observed.

i. Disciplining the witness to release the data held in their body

Figure 5.13 Lines 5 and 8 record Gareth teaching the patient the specific movements he wants the patient to perform. Rather than asking the patient to simply raise his arm, Gareth draws on his physiotherapy knowledge of the internal anatomy of the shoulder joint to request specific movements that will test (by stretching and compressing) different anatomical features in and around the joint. Through the direction of the patient’s movement, Gareth is testing or trying to ‘clear’ (as unaffected) possible reasons for the patient’s presenting symptoms. In addition, in Lines 13 and 14, Gareth uses a specific physiotherapy expression to get a specific physical response. The term ‘let it go’ is the typical way in which students asked patients to stop moving the limb they were handling so that the student could feel the quality of that movement. Gareth’s direction and control of the patient’s movements through his use of words offer physiotherapy-relevant interpretations of Lynch and Macbeth’s term ‘Disciplining witnesses’ (1998, p. 277). In their study of primary school science lessons Lynch and Macbeth coined the term to refer to the teacher’s disciplining of the students’ way of seeing so that they became ‘accountable witnesses to the science’ (p. 281) occurring in the desk top beaker (rather than simply noticing that coloured water and ice were in it). While we have seen similar PEd-led disciplining of student thinking and ‘seeing’ in this study, here we see a patient being taught (disciplined) to release the type of data Gareth knows he needs, in the form that Gareth wants.
ii. Controlling the environment so I can ‘feel’

Two interaction sequences in Figure 5.13 illustrate other strategies by which Gareth maximises the data he is collecting through his hands. Firstly in Line 18 Gareth tells the patient ‘I'll just lower you down a bit’. Implicit in this statement is the fact that Gareth is lowering the plinth on which the patient is lying so that it is at a height that will enable him to move the patient’s arm smoothly through its range of movement. Any jerkiness in Gareth's own movement would distort the ‘feel’ of the patient’s joints he is detecting through his hands. As the accompanying sketch illustrates (Figure 5.13 Sketch 3), Gareth is adopting a wide stance that enables him to take the patient’s long arm (note in Sketch 1 that the patient is taller than Gareth) through range. Secondly in Lines 16 and 20, Gareth is in deep, silent concentration while he moves the patient’s arm. This deep concentration was a typical practice throughout my data and is reminiscent of Rose’s observations in his ethnographic study of physiotherapy students’ university-based skills sessions (1999). Rose described touch as the ‘primary means by which [students] get good information about a patient’s condition’ and identified the students ‘own body’ as ‘both the tool and gauge’ for the collection of that information (p. 140). Figure 5.13 illustrates Gareth’s ‘interactive play between hand and mind’ as he tries to make sense of what he is feeling in a way that can be expressed in physiotherapy terms on the patient’s notes (Rose 1999, p. 152).

iii. Attending to note taking

The final strategy Gareth adopts to ensure the quality of the data he collects is his frequent and explicit recording of his findings. The importance of note writing in MSk student: patient interactions is visible both by its frequency as a stand-alone activity and, as illustrated in Figure 5.13 Lines 9 and 10, by Gareth’s focus on this task rather than the comfort of his patient. In earlier discussions about the subjective phase of a new patient assessment I noted that one reason for the centrality of the note writing process is, as in other science-based work environments, a setting down and making visible of the intangible elements that create that science. While this argument applies to the objective assessment too, the context of this interaction in a health setting adds a further dimension to note writing prominence.

Twigg (2000; Twigg et al. 2011) discusses the challenges, both in terms of professional prestige and social accountability, facing health care workers whose primary object of work is the human body. Building on the work of Emerson and colleagues, Twigg recognises the potential social tensions of people touching each other’s bodies in public places. Twigg discusses additional ‘distancing techniques' that professional body workers like
physiotherapists adopt to ‘transform their [patients’] bodies into appropriate objects of labour (2011, p. 179). She suggests that one such strategy is to turn the patient into ‘quantifiable data’ (2000, p. 137). Twigg argues that taking notes that remove the human patient from the body that elicited the data both reduces patients’ ‘feelings of vulnerability’ in the bodywork experience (2011, p. 179), and provides data that, through successful professional glossing, can be used to mark out an advanced, more medically comparable professional niche for the profession (2000, p. 137). I will consider the relevance of Twigg’s second observation in the context of physiotherapy’s professional project in later sections of this chapter. Here the use of objective data collection as a way to protect patient vulnerability leads me to consider the evidence of patient-specific work visible in Figure 5.13.

Emerson (1970) and Heath (1986) both identify the creation and maintenance of interaction participant ‘co-presence’ as an essential element of the physical examination phase of a patient assessment. As we saw earlier ‘the mutual involvement’ of both parties is needed so that the ‘normal trouble’ of this unusual interaction can be managed without inappropriate performances by either interaction participation ‘threatening’ the smooth progression of the examination (Emerson 1970, p. 85). Heath explores the ‘delicate affair’ of a physical medical examination in close detail (Heath 1986, p. 50). Through his ethnomethodological study of medical doctor: patient physical assessments, Heath makes visible the work being done by patients during these interactions. Heath described patients as needing to ‘hand over their bodies for test and inspection’ by ‘relinquishing some sensitivity over their body so as to render it an object for analysis’ (p. 100). Heath’s use of the word ‘some’ is important here. In Figure 5.13 there are times when Gareth speaks to the patient and expects him to respond directly to the given request (for example Lines 5, 13-14). At other times the patient is expected to be still and not introduce any distracting verbal or physical elements into the interaction. In Lines 16 and 20 Gareth’s patient adopts ‘a characteristic pose… as if looking into the middle distance’ (Heath 1986, p. 108). By ‘orientating neither to the foreground or the background but rather an apparent middle domain’, Gareth’s patient is managing to ‘disattend’ to the body work being performed on him, while remaining sufficiently attentive to ‘changes in the articulation of the activity’ to respond if required to do so (p. 118).

iv. Beginning to break the co-presence

Finally, Figure 5.15 suggests that the students are using both their verbal requests and physical withdrawal as opportunities to ‘break [their] co-presence’ and begin the process of drawing the assessment interaction to its final stages (Heath 1986, p. 129). Heath (1986)
reports re-dressing as the first step in ‘disentangling participants from a web of interactional commitment’ that was necessarily in place during the preceding physical examination.

Learning in and from objective assessments

The empirical data has illustrated the typical multi-faceted and intuitively complex work being undertaken by students and patients in the practical accomplishment of the physical assessment phase of a new patient assessment. Markedly absent from the setting are explicit planned opportunities for PEd-led learning because, except for Gareth's session with Belinda, the PEds were absent from all but the last few minutes of the interaction (e.g. Caroline reappearance in Figure 5.15c). In the next section we will see how the main learning opportunities occur in the debriefs that follow the assessments by virtue of what the PEds choose to select as the focus of that debrief and what they choose to ignore. To draw the current section to a close I discuss the consistent learning opportunity that did take place during the PEd-absent assessments: the trial and error opportunities for student skills practice.

Figure 5.16 follows Emily as she learns the best way to position her body and hands so that she is able to perform a smooth full range passive movement on her patient’s shoulder. Her challenge is similar to that facing Gareth in Figure 5.13 Sketch 3. While Gareth was able to resolve his physical challenges by simply lowering the bed, the sketches in Figure 5.16 suggest that Emily is standing in the wrong place (in Sketch 1 her body is blocking the movement she is trying to perform) and thus using the wrong handling technique to perform the movement she is wanting. In Sketch 2 Emily corrects her position and proceeds with no impact on or risk to the patient.

Figure 5.16: Learning to reposition body and hands through trial and error.

| Sketch 1: Emily is getting mixed up in her own arms. | Sketch 2: Movement now performed smoothly; patient adopts gaze away from Emily – fixed onto curtains. |
The absence of the PEd and, as we saw in the subjective-debrief, the consistent lack of PEd attention to the student’s skills proficiency, led to two occasions (illustrated in Figure 5.17) when I perceived patients to be at risk in their student’s care. As discussed in Chapter 3 I acted instinctively and intervened. In both cases the risk I perceived to the patient was through their compliance to perform activities, or have activities performed on them, that they must have felt were not correct. In Figure 5.17a Emily is performing a ‘Special test’ she has not performed before. During her subjective debrief Emily mentioned this to the PEd and was advised to ‘have a go and if you need me to come in then just ask’. A stretch of this kind would have been felt throughout the patient’s spine and is not normally applied in standing. The patient in Figure 5.17b was not at risk, but he was taking considerable strain for his leg activity on his neck muscles because he had no neck pillow. In both instances, having moved to intervene, the students immediately stopped what they were doing (before I had physically arrived at the interaction space), shot me a small smile and adjusted what they were doing / asking the patient to do.

Figure 5.17: Potential patient risk in student-led physical assessments

| Figure 5.17a: Emily performing a full neck flexion over-pressure on a patient in unsupported standing. | Figure 5.17b: Louise asking a patient to perform resisted leg exercises post knee replacement with an unsupported upper body. |

The next section returns to our exploration of students’ patient-facing interactions and the post objective assessment debrief specifically.
vii) The post-objective assessment debrief

The field note extracts in Figures 5.18 and 5.19 illustrate the typical conduct, focus and outcomes of a post-objective assessment debrief. Both examples capture the students’ normal debrief experiences where a PEd had only been able to observe the last few minutes of the objective assessment. In this section I explore the data to suggest that, while this interaction is in many ways similar to the subjective debrief, the objective debrief is accomplishing other work in the student’s learning to become a physiotherapist.

Figure 5.18: Belinda leading Gareth’s post-objective assessment debrief

1 10.17 am Debrief standing in gym. Belinda and Gareth each hold their notes (Sketch below, Gareth on right).

3 Belinda: ‘So what does that make you think?’
4 Gareth: ‘His AC joint.’
5 Belinda: ‘So if we are thinking ac joint with local palpation, what else did you do to test it?’
6 Gareth: ‘I did a scarf test…’
7 Belinda watching and nodding, seeks clarification. Gareth refers to his notes.
8 Belinda: ‘So are you thinking more Musculoskeletal or arthrogenic, so more of a jointy problem?’ Clarifies further, moving her arm to demonstrate.
9 Gareth responds: …. ‘So does that mean…?’
10 Belinda: ‘Yes’ and reels off an explanation.
11 10.20 am Belinda: ‘So if you have to put a diagnosis on it, it is difficult isn’t it, you are doing lots of tests. So I think you are right to say that you can’t say for sure. So what are you going to tell the patient about what you think is going on?’
12 Gareth puts down his notes and pen: ‘Umm, well his posture.’
13 Belinda: ‘So what structures may be causing his pain?’
14 Gareth responds.
15 Belinda: ‘If we relate it to his problems, why linked into his symptoms?’
16 Gareth: ‘Well they are loading the muscles so…’
Belinda watching, still, nods than explains. Touches Gareth’s left shoulder.

Belinda’s: ‘So I’d say … and explain to him…’

Gareth picks up notes and writes.

Belinda: ‘So what are you going to tell him about his physio? Next time when he comes in do more on postural advice.’

10.26 am Belinda: ‘What are you going to tell him about progress?’

Gareth offers

Belinda: ‘See if it (pt taking rest) makes a difference, it is a balance between keeping going and rest. Don’t give any suggestion that he should stop work or anything. Sounds good.’

The data in Figure 5.18 suggest that the post-objective debrief has two distinct steps. First the PEd develops the student’s clinical reasoning. Using the language of physiotherapy (Lines 5, 8, 10) Belinda asks what Gareth is ‘thinking’ (Lines 3, 5, 8) and helps him see the physiotherapeutic significance of his objective findings. In Line 16, the debrief moves to its second step where, as in the subjective debrief, Belinda prepares Gareth for the next phase of the patient contact interaction. The verbal elements of the two debrief interactions appear to perform the same roles in developing the students’ clinical reasoning skills. However, the proxemics sketches in Figures 5.18 and 5.19 illustrate different spatial dynamics from those in Figure 5.8 and suggest that the post-objective debrief is performing different work than its earlier counterpart.

Figure 5.19: The proxemics of a typical post-new patient objective assessment debrief. The PEd (Caroline) stands on the left with her arms crossed.

Caroline has been in and out of objective phase while seeing to John too.

Caroline: ‘So what have you found?’

Louise reports.

Caroline: ‘So we know that he has problems with that side so not directly comparable.’

Louise offers.

Caroline: ‘Yes fine that is really good…. Was it a stiffness in the joint or a lag?’

Louise replies ‘…When done passively.’
The proxemics sketches in Figures 5.18-19 suggest that post-objective debriefs are more physically dynamic, and the patient’s notes a less prominent presence, than in the subjective debrief. In Figure 5.18 Gareth holds the notes in his hand while he talks at the start of the debrief, but in Line 17 he puts them down. In Figure 5.19 neither Caroline nor Louise carry the notes. In both examples the PEds have their arms crossed at the start of the interaction as they listen carefully to their student’s talk and Louise and Gareth use their hands freely in gesticulation. Remembering that neither PEd has seen the students collecting their objective data, and knowing too the care with which the students have collected and recorded that data, it is surprising that the physical notes are not consulted. The data suggest that the post-objective assessment debrief is being used to develop students’ oral reasoning skills i.e. their ability to describe and defend their objective assessment ‘findings’ in a way that is understandable to a fellow therapist. This creation of physiotherapy from (patient) data is an example of situated learning in action.

As discussed in Chapter 2, Lave and Wenger suggest that, in a situated learning environment, ‘the issue of conferring legitimacy is more important than the issue of providing teaching’ (1991, p. 92). The post-objective debrief extracts in Figures 5.18 and 5.19 illustrate PEds ‘conferring legitimacy’ to their students through their verbal and nonverbal communication practice. Both Belinda and Caroline use the term ‘we’ and words of positive endorsement (e.g. ‘Good, exactly’ in Figure 5.19 Line 11) to demonstrate the physiotherapy-legitimacy of the students’ ideas and explanations. Perhaps more importantly in both debrief interactions are the PEds’ kinesics. In both debriefs the PEds give the students direct eye contact while standing completely still (for example Figure 5.18 Lines 7 and 22) until they physically endorse the students’ talk through head nodding, and in Belinda’s case, moving into Gareth’s personal space to touch his shoulder (Line 22). The proxemics, verbal and kinesics elements of the debrief work together to enable the students to get physically closer and share more eye contact with their PEds as outward signs of their increasing access to physiotherapy’s shared ‘common code’ (Lave and Wenger 1991, p. 21). Each post objective
debrief I observed ended with the students feeling buoyant (see for example Louise’s use of the colloquial term ‘Cool’ Figure 5.19 Line 20) and returning to their patient assured that they were ‘acquiring community membership’ in this placement (Gherardi 2006, p. 69).

Figures 5.18 and 5.19 also suggest that the ‘common code’ shared in this context is of physiotherapist control over the patient’s treatment. In Figure 5.18 Line 25 Belinda asks ‘What are you going to tell him’, while Caroline uses a related expression in Figure 5.19 Line 9: ‘What are you going to give him to go home?’ In no debrief did a PEd suggest that the student should ask the patient for their ideas about how their physiotherapy management could be progressed. In sum, the post-objective debrief was a powerful situated learning experience that implicitly endorsed a patient absent discourse of physiotherapy. The next section continues our observation of the students and explores the closing sections of a new MSk outpatient assessment as they returned to their patients to tell them the plans for their treatment that have been designed for them in their absence.

viii) Closing the patient interaction

The final patient contact phase of a new patient assessment sees the student return to their patient who, now usually dressed, sits waiting in the cubicle. In all cases students were approaching the end of their scheduled one hour session when they went back to re-join the patient. Figure 5.20 records the typical final phases of the student: patient interaction.

Figure 5.20: Gareth teaching his patient some home exercises

10.29 am Back with patient.
1 Gareth: ‘Well just a few things to go through. I will get a skeleton to show you.’
2 Demonstrates what he thinks is going on to patient using skeleton - patient looks decidedly uncomfortable (sketch below).
Gareth puts skeleton to one side and shows patient using body figure in notes (Sketch below).

Gareth: ‘Put an ice pack in a damp T-towel for 10-15 minutes.’ Pt listening, eye contact ++
10.34 am Postural advice.
Gareth: ‘Stand up nice and tall. Back against the wall, lift your scapula and drop. Does that make sense?’
Pt pulls a face
Belinda and CK exchange looks;
Gareth explains again: ‘Lift your sternum, shoulders down, scapular drops OK? Hold for 5 seconds. Do for about 5 minutes, try to build into your day and set time with your watch.’
10.37 am
Gareth: ‘So hopefully that will settle it down and then we can take it from there next time. I will try to book you in for about a week OK?’ Hand on curtain, opens curtain.
Pt grabs coat, gets up and follows.
Belinda starts talking to me about study - can only watch while Gareth makes appointment,
writes card, smiles to patient and says good bye.
Belinda to Gareth: ‘Do you want to have a break and then come back and write up?’

Analysis of the final phases of new patient interactions suggests that they achieve three things: teaching patients physical activities that can be performed at home in order to start their rehabilitation, closing the cubicle-based interaction, and booking the patient’s next appointment. Figure 5.20 is unusual because it records a student explaining to the patient (though perhaps a little too graphically for this patient!) what he thinks is the underlying cause of the patient’s presenting symptoms. In most cases, as illustrated by Louise’s ‘Hello, I’ve got some exercises to give you for home’, the student re-joins the patient with an enthusiastic reference to giving them something to do.

Having spent 5-7 minutes teaching the patient some exercises, each student progressed to an almost identical 3 minute session closure interaction. The brevity and dominance of the students in these closing interactions are consistent observations across my data. Figure 5.20 Line 12 illustrates Gareth’s control of the verbal elements of the interaction by using
‘technical talk’ (Emerson 1970, p. 83) to describe the patient’s exercises. In addition, through his use of assertive verbs (e.g. Line 13), Gareth controls the pace and focus of the dialogue and gives his patient no space to interrupt. In two short sentences, and using interaction practices that resonate with those described by Schegloff and Sacks (1974) in their study of the closing sequences of social interactions, Gareth signals and effects interaction closure. In the first phrase of Line 15 Gareth signals the ‘pre-closing’ (Schegloff and Sacks 1974, p. 246) phase by drawing the patient’s attention back to the beginning of their interaction: the reason for their referral. Within the same sentence, and without giving the patient the opportunity to delay the closing through the ‘insertion of unmentionable mentionables’ (for example to query his exercises or offer something about his condition presentation that Gareth has not asked him about; p. 257), Gareth signals the end of the current session with reference to a future interaction. Finally, in Line 16 Gareth ‘announces’ the closing with the single expression ‘OK?’ (Schegloff and Sacks 1974, p. 250). Belinda’s presence during the final minutes of Gareth’s session, and her lack of comment about its substance, suggest that the dialogue she observed was as expected.

Figure 5.20 Line 16 captures Gareth’s physical action that, accompanying his verbal closing sequence, marked the transition from the exercise-teaching to appointment-making phase. In all MSk closing sequences students moved towards the ‘door’ of the cubicle and grasped an edge of the curtain in one hand. Consistently the patients then reached for their coats and stood up. Readers will recall that similar combined verbal and movement closing sequences were used in the termination of neurology-based outpatient interactions with therapists holding the treatment room door handle as their patients grappled for coats and bags. This verbal / movement practice is reminiscent of Heath and Luff’s (2012) analysis of the closing sequences of auction house bidding interactions. Heath and Luff use the term ‘embodied action’ to describe the ‘distinct actions’ displayed in a ‘consistent series of competent movements’ that, understood by all interaction participants, led the interaction ‘unambiguously’ to its closure (2012, pp. 9-10). In this study the combined verbal and movement sequences of each MSk student was recognised by their patient and they left the cubicle.

Once the cubicle-based phase of the interaction was closed, students led the patient back to the Treatment Room’s desk area to book another appointment (e.g. Figure 5.20 Line 17). Each time, without being asked, the patient went to the front of the desk to face the students while they, behind the desk, looked at their electronic diary on the computer screen. When a suitable appointment had been made the patient and student said their goodbyes. Despite the smiles and collaborative breaking of their co-presence (Heath 1986), the typical MSk
student-led closing sequence kept the control of the interaction with the student. Edwards and Richardson suggest that leaving therapeutic interactions with this power dimension reduces the patient’s ownership for the rehabilitation of their condition and runs counter to the expectations of a twenty-first century healthcare system (2008).

ix) Writing up and signing off the patient’s treatment record

As we saw in the neuro placement, each MSk patient-facing interaction ended with note writing. Unlike the neuro context however, the final note writing and signing off interactions between PEd and student were brief. Amy’s note-related interaction with Emily in Figure 5.21 is typical.

Figure 5.21: Amy (PEd) completing a new patient assessment record sign-off

1 10.40 am
2 Amy back. To Emily: ‘Have you written up? Do you want me to have a look?’
3 Reads, silence, signs, hands back.

Two field note extracts were recorded when PEds had more time to focus on the note signing-off process. The data in Figures 5.22 and 5.23 will be discussed here before I draw this section to a close.

a. Note writing as accounting practice

In Figures 5.22 and 5.23 the notes become the focus of visual and tactile scrutiny. In Figure 5.22 Caroline scans the notes with her pen while she verbalises her thoughts about what Louise has written. Through her words Caroline makes visible the type of information and item construction that is valued in an MSk record and illustrates practice reminiscent of that Garfinkel (in collaboration with Bittner; 1974a) observed in their extensive study of medical clinical record writing. In his paper Garfinkel observes that, while the medical note writers’ practices appeared to be broadly framed within ‘rules, words and operating procedures’ (p. 114), they were also grounded in the expectations and ‘linguistic interpretations’ of the local culture (1974a, p. 118).

Figure 5.23 Line13 provides a sense of the purpose of note writing: the creation of a treatment plan for the patient’s rehabilitation. While this would seem an obvious outcome of the assessment process, I focus upon it because it is clear that this treatment plan creation is being completed physically and philosophically away from the patient whom it concerns.
Reminiscent of the work of Latour (1990) and Amann and Knorr Cetina (1990), the notes here have taken on a form of their own that does not require linkage to the object of its content data. This translation of a person into a human-absent clinical note creates a ‘bad’ or ‘non-actuarial record’ of the therapist: patient interaction (Garfinkel 1974a, p. 119). Garfinkel uses the term ‘bad’ to refer to the patient-distant creation of medical records that, in his view ‘serve the interests of [physiotherapy] services rather than the interest’ of patients (p. 126). As in the neurology placement students are learning to create, in physiotherapy-specific ways, artefacts that make visible and account for their professional practice.

Figure 5.22: An MSk PEd signing off a student’s written record. Caroline is on the right in the sketch.

1 12.20 Caroline back to discuss new patient card. Reads while standing. ? skimming subjective as saw this before?
2 Caroline reads: ‘Good, good, you cleared well – so just be aware next time… You got good detail in the social history which is good. That is laid out well, and very detailed.’
3 Takes pen from jumper pocket and clicks it.
4 Louise: ‘I also did the front.’
5 Caroline: ‘Cool, OK. I’ll just have a look at that too. (Leans forward to rest on table, pen resting on notes: Sketch below) OK you could have said about the distance and time.’
6 Louise: ‘OK I’ll put that back in.’
7 Caroline signs.

b. Note writing as confirmation of community membership

The second broad purpose of the note writing sign off interaction is to endorse students’ progress towards creating written records that articulate successfully the ‘common code’ shared by MSk physiotherapy community here (Lave and Wenger 1991, p. 21). In Figure 5.22 Lines 3-4 Caroline uses the word ‘good’ four times in quick succession. Similarly
Belinda, in Figure 5.23, uses the expression ‘Good, a good plan’ before moving the conversation onto the students’ next activities.

c. Note writing debriefs as an opportunity for peer-assisted learning

Finally in this section I draw attention to Figure 5.23 Lines 7-15. This short interaction sequence is the only extract in my data set where the ‘second’ student was a visible, though peripheral, interaction participant. Alice, the second student, had no patients booked for the time of Gareth’s note writing and signing off discussion so turned from her own notes to face the discussion between Gareth and Belinda. The sketch in Figure 5.23 suggests that Alice is not at ease in her role as listener, and, as illustrated in Line 8, startles as Belinda directs a question at her. Alice recovers and makes an appropriate response (note Belinda’s confirmation in Line 11), but her surprise recognises the uniqueness of the second student being drawn into a debrief in this way. Despite Megan and Naomi’s suggestion that one of the benefits of having two students together on a placement was that they could learn from each other, in practice Belinda was the only PEd I observed who attempted 2-student patient-specific learning activities and encouraged their observation of each other’s patient interactions (Line 13).

Figure 5.23: Illustrating the work being done by the note writing process.

<table>
<thead>
<tr>
<th>2.37 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Alice (student 2) has no patients and has just come back with a book from the library. Sits a little apart from Gareth and Belinda (Sketch below).</td>
</tr>
<tr>
<td>3 Gareth offers… ‘So say that everything goes swimmingly and her control improves, how is that going to affect her pain, is it because…?’</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>
Belinda expands… ‘It will give the area a bit more support, settle the rest down. Taping temporarily would give her support – proprioceptive [joint position sense] taping, like a stirrup – rather than waiting for things to build up. How else could you …?’ Turns to Alice; Alice: ‘Sorry’… offers ‘Proprioception objective markers like we did with Brian.’ Gareth: ‘What is that?’ Alice explains: ‘You know we did….’ Belinda: ‘Yes good’ Silence as Gareth writes out plan. Belinda: ‘Good, a good plan. Gareth, Alice has a new one now, do you want to do your notes or watch?’ Gareth: ‘Watch please.’ Smiles to Alice.

5.4 Reflections from the observation of students at work in ‘core' MSk patient interactions

This chapter has explored the practical accomplishment of student: patient interactions during their ‘core’ work in the MSk outpatient department and the students’ opportunities for learning within that practice. At the time of my fieldwork students’ primary activity was the assessment of new patients booked into their online diaries by the departmental administrator. This chapter has described and discussed the phases of student-led new MSk patient assessments and the learning that the placement teaching practices privilege. Collating this data demonstrates the consistency of student experiences and practices across MSk placements, and suggests the following basic sequencing of new patient assessments:

- c 1 minute pre-assessment planning,
- c 15 minutes subjective patient assessment,
- 5-10 minutes away-from-patient debrief and planning for the objective assessment,
- c 15 minutes objective assessment,
- a further 5 -10 minutes away from the patient to plan intervention,
- 10 minutes to give patient exercises, book the next appointment and say goodbyes.

This consistent timing pattern also illustrates the learning opportunities MSk students experienced. Here I briefly compare these to the experiences of neuro students discussed in Chapter 4. Firstly, while the basic assessment sequencing followed a similar pattern in both settings i.e. pre-planning, subjective assessment, objective assessment, post assessment debriefs and note writing and signing off, the student: PEd interactions differed. In the neuro placement the PEds prepared their students for co-working in patient-contact interactions and, never leaving the patient alone once a physiotherapy interaction had commenced, discussed their assessment ‘findings’ in the presence of their patient. In contrast, on the MSk
placement, we have seen students undertaking the patient-facing elements of a new patient assessment with their PEd either observing from a distance or absent altogether. In the MSk setting the locally imposed structure of student-led new patient assessments required them to leave the patient's cubicle usually twice in the hour scheduled for the session. These patient-absent sessions were used for PEd-led teaching sessions framed about the students' written and verbal interpretation of the patient data they were collecting. The structure of the new patient assessments and the focus of the debriefs on clinical reasoning reflected the PEd Duty Leader's overall vision for placement education.

Secondly the data suggest that MSk PEds see their role as a daily activity with little visible evidence of their ownership for the students' whole learning experience. This observation is different from the neuro placement where each activity with which the students engaged had been selected for a purpose. The final MSk: neuro organisation-related placement difference is the presence of a second MSk student. The data discussed here suggest that the PEds organise the MSk placement as two 1:1 placements. This approach, coupled with the local format of patient-related teaching, places pressure on students to complete patient-facing interactions in a timely manner, or one that is quicker than that of their fellow student.

I have drawn on sociological literature to suggest that the practices students perform and the teaching they receive are both framed in discourses of science and a biomedical model of health care. We have seen students disciplined to create the case for physiotherapy from data collected from patients who are otherwise absent in the decision-making processes about their treatment. By combining field note, proxemics and kinesics stave data I have made visible the practical accomplishment of placement education in an environment that privileges the hypothetico-deductive model of clinical reasoning as the main outcome from students' learning during 'core' MSk work.

5.5 A brief aside: observations of MSk students’ learning in other settings

Readers will recall that Ian's other objective for his MSk placement was to develop students' MSk related technical skills, and that MSk students worked with patients in 'duty-role' contexts. Before I move away from the MSk context it is important to alert readers to the detailed discussion of students' learning in these non-clinical-reasoning-focused settings that are created as stand-alone case-studies in Appendices 5 and 6. As discussed at the start of this chapter I decided to focus the main text on the MSk students' experiences that resonated with practices of their neuro placement peers. The hydrotherapy and technical
skills learning data are additional experiences for MSk students and have thus been placed elsewhere and will be discussed in Chapter 6.

5.6 Chapter summary

This chapter and the related case studies have explored in detail the typical placement learning activities of third year students at the start of their second of four weeks on a specific outpatient-based musculoskeletal placement. Collectively the texts have illustrated how the University’s required learning outcomes for a Level 6 MSk placement were used to create a framework for placement education that, influenced by environmental and interactional features of the local context, was translated into student learning experiences. Like their neuro peers, MSk students were engaged in patient-facing activities (both core and duty work) for c 60% of their day and filled the remainder with non-patient-specific activities for example self-study, techniques sessions with staff and breaks.

Analysing the data has alerted me to patterns and consistency in the ways in which some interaction practices were performed irrespective of the specific players in the interaction and suggested a shared expectation of the requirements and intentions of these interactions. Collectively the data have made visible the PEds’ prioritisation of clinical reasoning facilitation rather than demonstration of patient-facing interaction and therapeutic skill development. The chapter has explored the centrality of implicit situated learning influences on the placement education practice at this site and attempted to make visible the consequent place of the patient in the learning setting.

Having explored the practical ways in which placement education is achieved in the neurology and MSk placement settings, the next chapter looks across both datasets to consider the evidence both for cross-placement consistent practice and disciplinary specific differences in the practices and work being done by placement education interactions.

6.1 Introduction

Chapters 4 and 5 charted the typical early placement education experiences of six physiotherapy students at two hospital sites. In addition the chapters evidenced my personal learning journey in noticing and making visible some of the minutiae of everyday participant interactions in these settings. Having explored the data from each placement site in detail, I am now in a position to see interaction practice similarities and differences emerging from force of circumstance i.e. that certain circumstances and needs come together to create performances and the accomplishment of tasks in certain ways. Thus, while some specifics could be expected to vary because the individual humans performing the activities and interactions vary, distinct patterns have emerged in the broad field of practices. In this chapter I revisit the patterns observed in the neurology (neuro) and musculoskeletal (MSk) settings as features of normal interactions of the players doing being occupationally ordinary in each site as they go about doing specific forms of work. Having identified emergent themes in both settings I will explore and discuss their cross-placement relevance.

The chapter is structured in five sections. The first section recalls the discussion in Chapter 3 about the process by which the analysis and synthesis of the study data were undertaken. The next two sections comprise the main body of the chapter as I present and discuss the outcomes of the analysis. The final two sections draw together the ideas emerging from the analysis to begin the process of refocusing the project on the student learning experience in the last chapter of this thesis.

6.2 The process of data analysis and synthesis

In this chapter I have undertaken a three part analysis influenced by Gubrium and Holstein’s ideas about the ‘hows’ and ‘whats’ (2000) of social practices. I first use the data in Chapters 4 and 5 to draw out and theme the enactment of locally performed practical reasoning or the ‘hows’ by which members establish and sustain social regularities in each placement area. Where appropriate I support the discussions with data from elsewhere in my dataset including the post-observation interview transcripts. By embedding the discussions in data I aim to let the placement participants’ voices and actions speak for themselves (Pollner 2012). Having explored themes in one context, I then test the application of each group’s
interaction practices in the context of the other group. Finally, recognising that these ‘hows’ are evidence of the work of the social group members to ‘do being ordinary’ while performing set tasks within a set context (the institutional and cultural discourses for example) and with the physical resources to hand, the chapter will consider the interplay between these ‘whats’ of social reality and the ‘hows’ by which everyday life is accomplished.

Table 6.1 summarises the categories of practices that arose from my analysis of the running data sequences in each of the results chapters. In the next sections I explain the practices that the terms in Table 6.1 represent and how they emerged from a close interrogation of the relevant dataset. The discussion of each practice concludes by testing its relevance in the context of the other placement setting.

Table 6.1: Emergent locally consistent interaction practices.

<table>
<thead>
<tr>
<th>Neuro practices</th>
<th>MSk practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. ‘Intercorporeal knowing’ in action (after Hindmarsh and Pilnick 2007)</td>
<td>i. Placement educator led student debriefs</td>
</tr>
<tr>
<td>ii. The over-the-patient verbal practices of PEds</td>
<td>ii. Student: student interactions</td>
</tr>
<tr>
<td>iii. Interaction practices between physiotherapists</td>
<td>iii. Lone student: patient interactions</td>
</tr>
</tbody>
</table>

6.3 The ‘hows’ of the neurology placement

In this section I take the neuro practices listed in Table 6.1 and describe how the practice emerges from an analysis of the neuro data. Having discussed that practice in the neuro context, I explore its relevance in the context of the musculoskeletal placement.

i) The practice of Intercorporeal knowing

‘Intercorporeal knowing’ is a term adopted by Hindmarsh and Pilnick to refer to practices they observed when studying interactions in a hospital operating theatre (2007). Theatre staff were observed interacting in nonverbal ways (for example passing equipment, altering bed heights etc.) to effect a smooth running operation. Hindmarsh and Pilnick noted the absence of linked verbal commentary for many of the body actions they observed and described the interaction practices as evidence of the team’s ‘practical knowledge of the dynamic bodies of others in the local ecology’ (p. 1396). The researchers suggested that, in
the context of an operating theatre, intercorporeal knowing was ‘a critical resource that … members use in accomplishing real-time coordination’ (p. 1412).

The idea of intercorporeal knowing is relevant in the context of neurological physiotherapy not only because physiotherapists work together in teams for most patients, but also because the nature of physiotherapy practice requires the use of their own bodies in direct contact with that of their patient. My neuro data is rich in examples of interaction sequences that illustrate both the presence and absence of intercorporeal knowing (IK) practices. The absence of IK in a junior therapist is discussed in Appendix 3 and illustrated as Figure 1. Here Figure 6.1 suggests effective IK in action. In the proxemics sketch Amelia is on the bed behind the patient with the student Stuart at the patient’s knees.

Figure 6.1: Intercorporeal knowing in action

| 1 | Amelia: ‘What we would like you to do is to sit on the edge of the bed.’ (Sketch below) |
| 2 | Pt: ‘OK’ |
| 3 | Amelia: ‘OK Stuart can you take the legs’. |
| 4 | Amelia and Stuart swing pt into sitting. |
| 5 | Amelia: ‘I’ll pop a pillow between us so you have something soft to rest on. (To Stuart) How is he doing? Leaning a bit?’ |
| 6 | Stuart: ‘Yeah a bit.’ |

The field note extract in Figure 6.1 records the interaction of three people to get one of them from lying to sitting on the edge of the bed ready to commence exercise. The absence of verbal interaction between Amelia and Stuart is striking. Stuart is an experienced third year student who has acted as a physiotherapy assistant (unqualified support worker whose role is often to support therapeutic sessions such as that in Figure 6.1). In addition the sketch
illustrates the closeness of Amelia’s body to that of her patient and the parallel alignment of her spine with his. Even without the insider knowledge of physiotherapy, a basic understanding of forces and physics makes clear that Amelia’s posture is more effective and efficient at supporting her patient in sitting than the junior’s efforts in Appendix 3. Analysis of the field notes and linked proxemics sketches in the neuro data suggests that IK is widely practised but never made explicit, taught or corrected within the neuro team. I now turn to the MSk data and test the relevance of IK ideas to the practices I observed with that group of therapists.

Exploring the MSk data for evidence of intercorporeal knowing suggests that, while it underpins every physical interaction between therapists and patients, explicit IK noticing or teaching is absent from MSk teaching interactions. Figure 4 Appendix 6 illustrates typical MSk-related IK practice. The Figure records a lunchtime skills teaching session lead by Naomi (Band 6 PEd coordinator). In Figure 4 Lines 7-9 Naomi verbalises the physical steps needed to perform the skill, but then, in Line 10, performs the skill itself in silence. The accompanying proxemics sketch demonstrates Naomi’s positioning of herself behind the ‘patient’ and direction of force application through her hands to affect the required physical reaction from the patient. The skill with which she matches the force she needs to apply to that provided by the model’s own efforts is not verbalised to help her students and peers ‘Go away and practise’ (Line 13).

Focusing attention on the between-body awareness of physiotherapists has not only made visible its centrality to the work they perform on their patients, but also suggests that some form of ‘intra-personal knowing’ or awareness of personal use of body in space is an essential prerequisite. Figure 7 (Appendix 6) presents two proxemics sketches that illustrate the same skill being performed by a student (7a) and an expert (7b). The sketches capture the student’s strain and potential self-risk, and the movement efficiency and fluidity of the expert. The sketches in Figure 7 suggest that a therapist needs to develop an awareness of their own personal body stress as well as being sensitive, through her hands, to patient’s needs (after Rose 1999).

An analysis of the data thus suggests that physiotherapy work in both placement contexts is grounded in physical interaction practices which have as their foundation an assumption of intra- and inter-corporeal knowing. Neither form of body awareness is taught explicitly in either the neuro or MSk placement.
ii) The verbal practices of placement educators

The second category of practices arising from an analysis of the neuro data (Table 6.1) was the verbal interaction practices of placement educators with their students during therapeutic sessions. Within the data I was able to compare the PEd practice of one therapist (Lucy) in both neuro ward and outpatient settings. As discussed in Chapter 4, Lucy adopted the verbal practices of her expert peers in the ward and (Figure 4.5) verbalised her own noticing, thinking and planning processes over the patient in the bed. In contrast, when observed as a PEd in the unfamiliar (to her) outpatient setting, Lucy was almost verbally absent from the interaction despite her supervising the student’s first new patient assessment in this setting (Figure 4.9a Lines 2-14).

This practice of neuro PEd silence during patient facing interactions was only observed when the students were working with PEds who had recently rotated placements. Analysis of the proxemics sketches capturing the physical interaction practices of these therapists (Lorna and Lucy) suggests that they practise Intercorporeal Knowing in ways similar to the Band 7 staff and reflecting their significant neuro therapy experience. Whatever the reason for the difference in verbal practices between the PEds who were experienced in the specific context in which they were acting as PEds and those newly rotated, the impact on the students was a recordable more halting and stilted interaction with their patients (see for example Figure 4.9a Line 7 and Figure 4.9b Lines 12-13, 21-29) and one which placed the patient (Figure 4.9a Line 5) and themselves (Figure 4.9b Line 10) at physical risk.

Both Verity and Isobel experienced placements where one of their PEds was a recently rotated Band 6. During my fieldwork I never saw Band 6 PEds being asked about, or observed while in, their PEd role. In her post placement interview Isobel (Figure 6.2) spontaneously spoke about the challenges she experienced when a newly rotated PEd (Lorna) was her lead PEd.

Figure 6.2: Isobel’s reflections on working with a rotation-specific inexperienced PEd.

1 ‘The chats that we [Isobel and Lucy] have about a patient are really, really productive, they really help me. I’ve been able to go away and do things and then come back and say “that was really good”. We can often talk about it afterwards, which is something that you don’t get chance to do on the ward… with this clinical educator I feel happy because I learn so much more and that really sort of gets me going a little bit. It sort of makes the rest of the day go a little bit better; I think ‘well I definitely got something out of that’.”
... [conversation progresses to a story about an experience on the ward with her recently rotated Band 6 PEd, Lorna] we got the patient where she needed to be, she didn’t know that anything was going on, but I was being said to “what do you want to do now”, “what could you do from here” and I just went blank really. And then afterwards the feedback was not negative, but just sort of half-hearted, .. so I really felt a need to prove myself then and I was really quite “I know I can do this”, I just wasn’t in the right frame of mind. I should have been because that’s how Physio is. But… yeah, I think the way that, it’s not to blame anyone else, because I should have known how to deal with it, and it was quite a simple exercise to do, … but I had never seen this patient before, we hadn’t talked about it before I went in, I just went in and did it… um… I think it was “what you going to do now?”. I did some things like, ‘let’s take the blood pressure’, I did do things but it felt not right.

The story reported in Figure 6.2 Lines 9-20 reflected Isobel’s typical ward-based experience and suggests that it was difficult for students to perform neuro physiotherapy when they were with a PEd who did not make the specifics of the practice of neuro physiotherapy visible in the moment. As illustrated in Lines 15-18 Isobel tries to deflect some of the responsibility for her perceived troubles from Lorna’s PEd practice onto herself. Her précis of the types of questions Lorna was asking in the patient-facing context (Lines 11-12) resonates with those I observed (see Figure 4.9b) and could be described as directive and closed: if Isobel was uncertain about a response there was nothing to guide her in the style of question for example. Remembering that my observations of the neuro students were in the first week of their placement, it is perhaps understandable that Isobel found directive questions unhelpful.

Having noticed that the more junior neuro PEds were practising in-the-presence-of-the patient placement education in a more directive, even formulaic, style than their more context-specific experienced colleagues, I analysed Lucy’s outpatient-based and Lorna’s ward-based away-from-patient debrief styles. Figure 6.3a extends the data in Figure 4.9a to follow Lucy’s debrief with Verity. Isobel did not receive a debrief session for the patient she saw with Lorna in Figure 4.9b because she had to rush down to an outpatient session. Figure 6.3b is thus an extract of the ward-based debrief between Lorna and Isobel for the same patient after his treatment the following day.

The proxemics sketch in Figure 6.3a captures the freedom and enthusiasm with which Lucy engages in her verbal interactions with Verity and replicates the related ward-based debrief sketch in Figure 4.12b. Despite the same level of personal engagement however, the accompanying field notes recording the verbal elements of the interaction differ. In Figure 4.12b Line 2 Lucy sets up the debrief as a shared thinking time and proceeds to both lead Verity through thinking processes and share her own perspectives. In Figure 6.3a however Lucy’s questioning style is task focused (Line 8), declarative (Lines 8, 11, 15) and reporting
(Line 15-17) in nature. This pattern of focus on task with declarative assertions and little room for, or encouragement of, student individual thought is replicated in Figure 6.3b with Lorna’s ward-based debrief with Isobel.

Figure 6.3: Neuro debrief sessions between ‘inexperienced’ PEds and their student.
Figure 6.3a: Lucy conducting an outpatient-based post patient debrief with Verity.

1 12.25 pm neuro outpatient office. Patient has just left.
2 Lucy sits in wheeled chair by desk, Verity in one by computer desk (sketch below)
3 Verity (on the right) moves the notes within view of Lucy, who leads the discussion.

4 Lucy: ‘So how did you feel that went?’
5 Verity: ‘Much happier.’
6 Lucy: ‘Let’s go back to the notes.’
7 Verity turns notes so Lucy can see;
8 Lucy reading and leading: ‘So you did this… but next time…yes that’s fine..’
9 Lucy to Verity eye contact ++
10 Lucy: ‘They often have problems with their….it was quite hard with him…. oh yes, about the trapped nerves, try not to go out on too many side things – not their main problem that you are here for… build up a repertoire of possible questions, just like we did with that lady yesterday.’
11 Verity: ‘He did say about not getting out – is the group an option?’
12 Lucy: ‘Yes we could, but I think to start with I’d do balance – if when comes to end says ‘oh this is great’ you could say there is this group and exercise on prescription scheme – I don’t know much about it here in Cardiff – must look at that today.

Figure 6.3b: Lorna’s post patient debrief with Isobel

1 3.45 pm at nursing station assessment debrief
2 Discuss issues of consent;
3 Lorna talking ++: ‘Your hands were moving all over… (Isobel watching intently, surprise passes over face, makes no defence / sound)… just takes a lot of practice. What I tend to do is… (Isobel watching face ++)… Depending on… I’d do…’
4 … What did you notice?’
5 Isobel: ‘Everything!’ Little laugh;
6 Lorna: ‘Well start off’. No laugh.
7 Isobel offers ++
8 Lorna expands watching Isobel’s face. Asks qu.
9 Isobel: ‘Not sure really.’
10 Lorna expands. Isobel watching Lorna very intently;
The analyses discussed in this section evidence the existence of a set, step-wise and patient-case-based approach to neuro student education, and a difference in the execution of that approach dependent on the specific expertise of the PEd. The data suggest that, while specialist Band 6 therapists have physiotherapeutic skill levels comparable to their Band 7 peers, they are more teacher-controlled and directive as PEds. As suggested by Isobel in Figure 6.2, and observed with Isobel and Verity in practice, a formulaic approach to education caused students to feel unsettled and uncertain in front of patients. Further, the data suggest that the approach of the junior neuro PEds did not lead to a more patient-inclusive interaction. Instead the data illustrate a consistently ‘patient-absent’ interaction style across all neuro student-present patient-facing interactions.

So are these ideas about PEd verbal practices relevant to and evidenced within the MSk dataset? Chapter 5 described the different organisation of the MSk outpatient placement with a ‘set’ of three PEds allocated to two students. During their PEd day the clinician’s role was to support the students’ clinical reasoning development. MSk outpatient PEds did not treat patients with their students and conducted the clinical reasoning sessions at a physical distance from the patient. With only minimal fieldwork data recording patient-present PEd: student interactions, I have focused on the MSk away-from-patient debriefs to explore how the MSk PEds conducted the verbal elements of their interaction with students.

Figures 5.8, 5.9 and 5.10 are typical examples of MSk PEd-led patient assessment student debriefs. Analysing the verbal elements of the field notes suggests that Amy (Figure 5.10, the less experienced MSk Band 6, and the PEd who did not observe her students’ assessments) questioned Emily using a closed and formulaic approach. Gareth’s PEd Brian was also new and, as illustrated in Figure 6.4 Gareth picked this up precisely because of the approach Brian adopted.
Gareth: ‘I kind of wonder, if this may or may not be true, but I wonder if Brian is the least experienced as a clinical educator... That’s not taking away anything from him, because he’s very measured and very thoughtful in what he does and how he approaches things… Um… I think sometimes there’s bits of detail that I think that Karen and Belinda may let that slide, they think maybe that’s not how we’d of done it, but that’s them, and I’m not going to even comment on it, maybe that they’re planning to come back to it at another time — and the fact that they do draw stuff out from you. I found them as well to be quite, you know all clineds at some point, take over in the conversation, and that’s fine because you’re kind of waiting for that wisdom, but I think they maybe see what you know a bit more first… which is a real skill. I wonder if Brian maybe steps in a little earlier.’

Gareth’s observations about Brian’s more controlled PEd approach resonate with my analysis of Lucy and Lorna’s verbal debriefing practices. Across the MSk and neuro datasets there is thus evidence that inexperienced PEds undertake the verbal elements of their role differently from their more experienced peers. In both settings the patient-facing work of students follows a similar pattern and will be explored in more detail later in this chapter. Here I make visible the difference in questioning approaches and suggest that, in a context where PEds do not sit in and observe each other’s education practices and thus notice the differences for themselves, the MSk pattern of each PEd only leading one day’s education at a time may ameliorate some of the education differences students experience.

iii) Interaction practices between group members

A notable feature of the ward-based neuro team practice was the extent and forms of interaction occurring between team members throughout the working day. In this section I analyse the neuro data to explore the work of intra-team interactions and the opportunities for learning they offered the students. I will then test the ideas that arise in the context of the MSk placement.

Analysing the neuro data identifies three forms of practice by which the neuro team interact: they interact verbally, spatially and indirectly through their shared written patient records. Readers will recall that the neuro placement is spread over two sites: a ward based placement which itself can cover the treatment of patients across four geographically dispersed wards, and a departmental outpatient-based site. Belinda, the Ward Band 7 therapist, has overall responsibility for the physiotherapy provided by her team of one static, specialist Band 6 and three rotational Band 5 staff. Belinda manages
the whereabouts of her team to ensure that all patients are treated by the appropriate number of staff and with the correct (and cleaned) piece of equipment. As illustrated in Appendix 2 Figure 1, Lines 20-36, Amelia’s twice daily short team updates in the outpatient office are key devices for her team management. Through her quiet talk to her team with the ward diary on her lap, Amelia both allocates staff to wards and makes clear that she is fully aware of their individual daily commitments. Throughout the neuro dataset there are repeated short extracts of field notes recording snippets of verbal interactions between Amelia and her team as they check-in with her physically (during patient treatment sessions), or via the bleep that Amelia carries. The skill with which Amelia manages the multiple challenges of the team while simultaneously acting as a PEd is noticed and commented on by students as illustrated in the short interview extract below.

Verity: ‘Amelia is really organised so she knows when or if I’m needed, she just organises everyone so well, she knows where everyone is going to be all day and the afternoons. I think she’s just good at saying “you’re on there”, “you’re on there”.’

Another use of verbal interaction (or rather its absence) is evidenced as Amelia leads her team, trailing equipment through hospital corridors, to the neuro wards. The neuro staff travelled as an identifiable group of uniformed staff through spaces shared with health workers and the general public. I have only one small field note entry of a socially focussed verbal interaction between Amelia, Verity and myself as we walked along a very remote corridor. At all other times the group passed from the department to their place of work in silence but with plenty of eye contact and door holding etc. for each other and people whom they passed. The absence of talk was striking given the size of the group, but appeared to serve the purpose of using the ‘walk’ as preparation for entering the work space of the ward.

As the neuro team approached the wards the individuals dispersed except where they were needed to co-treat a patient. This co-treating of patients was the second form of interaction students observed occurring between team members. In addition to the intercorporeal knowing practice implicitly gained by the physical interaction between members of the team through their work on a patient’s body as previously described, the co-working interaction consistently evidenced a specific spatial interaction. As illustrated in Appendix 3, every time three therapists worked together on a patient an unspoken spatial dance took place. Without verbal communication the Band 5 went behind the patient and prepared the bed area to enable her to kneel on it when required, the Band 6/7 therapist approached the head of the patient to ask a form of consent to treat, and
the student moved to the foot of the bed. Data analysis suggests that this spatial orientation achieves two outcomes. Firstly the patient is being surrounded and his environment silently prepared (bed lowered, table removed, cot sides dropped, catheter bag moved forwards, slippers passed to the student etc.) in a manner that passes control of the interaction to the therapists who have entered his personal space. Secondly the students are experiencing consent-gaining and unquestioned room shifting practices which they learn to enact and thus enforce. Even by the end of their first week on placement each third year neuro student was adept at this silent bed preparation dance and knew how the internal hierarchies within the trio affected the work each of the three was expected to perform in the therapeutic interaction.

The final neuro intra-team interaction to discuss here is their shared, often silent, note writing practice. In Chapter 4 I discussed field notes from both the neuro ward and outpatient settings that were littered with proxemics sketches recording communal note writing practices (e.g. Figure 4.13). The data illustrated the companionable silence in which note writing was performed with only PEd-led discussions with students being heard. The only time my field notes record non PEd-led verbal interaction was when, sitting alone with a Band 5 colleague (Gareth), Isobel broke the silence and asked him for advice (Figure 4.18). Isobel's use of Gareth suggests that she recognised him as a resource to unpack the locally expected written accounting practices.

Interaction between neuro therapists thus takes several forms and appears to be used - to bind the group together as a coherent team understood and known by the Band 7 (verbal interaction methods); - to get the complex work of multiple-handed patients performed in an efficient routine while also establishing an implicit internal hierarchy and patient control (spatial orientation methods), and - to ground the treatment of patients in a silently understood shared note writing practice.

The multiple forms of interaction appear to unite the neuro team in identity and patient-management practice. So what about intra-team interactions in the MSk context? In the rest of this section I test the ideas arising from my analysis of the neuro data in that context.

Team work is not an explicit feature of the MSk staff who work 1:1 with their patients. Analysing the MSk dataset for examples of intra-group interaction suggests that, while their practices differ from those of their neuro colleagues, the MSk group use peer
interaction means (which the students also experience first-hand) to affect similar outcomes: namely the maintenance of internal hierarchical structures and a sense of group identity. I evidence these ideas below.

Verbal interaction between MSk students and non-PEd staff was almost non-existent even though they shared a physical room. Even on their non-PEd days, I did not see the students’ PEds interact with them. Part of the distance between the groups was physical because the students occupied a separate corner of the Treatment Room. In their pre-observation interview Naomi and Megan spoke positively of this separation as providing an opportunity for the students to work together without being disturbed or overheard. In practice, with their backs, by necessity, turned to the rest of the room, the students seemed to be rendered invisible. Most notable during my observations, and commented on by each student in their post observation interview, was the so called ‘tea apartheid’: the apparent invisibility of students when tea / coffee making offers are being made. The short extract from Louise’s interview in Figure 6.5 is typical.

Figure 6.5: Students’ perspectives of their physical and verbal isolation in the MSk room.

Louise: ‘Well I don’t like coffee anyway, so it doesn’t bother me, but they always go “do you want a coffee?”, and they’ll say it to everyone else but they’ll never ask me or John, ever. On my other placements they’ve always said “I’m going for a coffee, do you want one?”, but never here have they asked us. And like, even if they’re going for break or something, I don’t know, they never really invite us along, they’ll be like “let’s go for break now”, it’s all very segregated.’

Gareth: ‘It comes down to personalities I think, I mean, they see students come and go all of the time, so there’s a huge element of that. But people are very happy to stop and offer help. As well I think I might of mentioned, about there was somebody sitting close by to us and I wasn’t sure if they were a bit standoffish or if they were a bit inexperienced and I’ve since found out a bit more about them, but I also went and introduced myself and sometimes that’s all that’s missing. People respond well to that.’

The first extract in Figure 6.5 captures the student’s sense of isolation. Gareth, the mature student described his similar feelings but, as illustrated in the second extract in Figure 6.5, he adopted an active approach to integration. His actions, and the positive way they were received, suggest that there is unlikely to be a deliberate attempt to exclude the visiting students. Perhaps the combined effects of physical separation, back-facing body postures, dedicated PEds and the assumption that the two students are all each other needs for company, compound to make the individual students and their needs invisible to other staff.
It is tempting to suggest that intra-group interactions are less important in the MSk than the neuro contexts. However, as illustrated in Chapter 5 and Appendix 6 intra-group interactions do exist and perform equally powerful group identity-building work to that of their neuro peers, but with the practices differing to reflect the context in which the therapists operate. Two forms of physical-based intra-group interactions were practised with, and in the company of, the students: the physical interaction between the student and PEd as the student was taught and practised physical skills (for example Figure 5.11), and the twice weekly physical interaction between therapists during the whole group ‘techniques sessions’. Figure 6.6 offers a related, but unique, example of a PEd teaching a student using her own body.

Figure 6.6: A PEd (Caroline) teaching a student to perform a skill using herself as the model.

1 Day 5 3.35 pm
2 Caroline to Louise: ‘So would you like to go through some hip handling?’
3 Louise takes off shoes, lies down to act as model;
4 Caroline talks through what she is doing and feeling in Louise’s body;
5 … 3.35 pm Caroline to Louise: ‘Do you do want to have a go?’
6 Swap roles, Louise practising on Caroline (proxemics sketches below)
7 Caroline: ‘So you might want to raise the bed a bit…. So now you should move me into…’
8 … 3.40 pm Caroline: ‘So tomorrow morning you can teach the hip to John.’

The proxemics sketches and field notes in Chapter 5, Appendix 6 and Figure 6.6 combine to illustrate the PEds’ use of physical, touch-based interaction practices to confirm the students’ right to be in this group. Lave and Wenger’s ideas about communities of practice and legitimate peripheral participation of newcomers into the local community of practitioners (Lave and Wenger 1991) have been discussed elsewhere and are powerfully evidenced in action through these extracts.
The second example of the MSk team’s use of physical intra-group interaction practices is illustrated in the data relating to the twice weekly whole group ‘techniques sessions’. As discussed in Appendix 6, the sessions were notionally to revise and practise specific techniques or skills and, as the only opportunity students had to regularly see qualified colleagues work together, had powerful socialisation potential. In Appendix 6 we explored field note data and proxemics sketches that made visible the routine practice of physiotherapists exposing each other’s body parts (and, with minimal requests for consent, adjust clothing to affect that outcome) in order that the ‘part’ needing attention could be seen and physically handled as necessary. Further, we saw staff separate along hierarchical lines during techniques sessions with students pairing together and occupying practice plinths adjacent to those occupied by Band 5 therapists and away from the similarly grouped Band 7s. The MSk team appears to be using physical and spatial interaction practices relevant to their context to socialise and maintain the seemingly invisible and unquestioned internal group hierarchies. Across the whole MSk department-based dataset physical touch-based interaction strategies, combined occasionally with short verbal instructions, are used to focus attention on the problem body part while simultaneously withdrawing the focus of attention from the human who owns the body part. Thus, while executed using different interaction strategies, the data suggest that both the neuro and MSk teams use intra-group practices (which they require their students to practise) that draw attention to their work while implicitly reducing the agency of their patients.

The final group interaction strategy employed by the MSk team is unique to the group and relates to practices observed in their work in and around the hydrotherapy pool. As discussed in Appendix 5, students, PEds and patients all get into the pool during hydrotherapy sessions. Everyone is thus in their swimwear and in close physical proximity. Given the explicit socialisation of body part observation practices discussed earlier in this section, the noticeable shift in therapists’ gaze during hydrotherapy sessions from body parts to each other’s eyes is striking (Appendix 5). The hydrotherapy data thus suggest that, while bare-part body gazing and physical contact is essential when at least one of the interaction participants is fully clothed, different interaction rules apply when everyone could be accused of, and exposed to, the vagaries of unsolicited body watching (Twigg 2000).

In this subsection I have explored the way that members of each therapist group interact and considered the work these interactions perform in socialising group identity. The different nature of each group’s employment focus has affected the forms of interaction
strategy available for regular use as a socialisation device. Thus while shared note writing and gaze holding / body-contact avoidance strategies are not transferrable practices across therapy contexts, they each serve to achieve social group coherence in their own context. Each group-specific strategy achieves similar practical outcomes: the maintenance of internal professional hierarchies and the ability to shift therapeutic interaction control from the patient to the therapist.

Section summary

The analysis in this section has illustrated how the verbal, physical and spatial interaction strategies neuro therapists use to complete their patient-facing tasks also work to create and maintain specific local group identity and interpretation of the tasks and focus of the neuro physiotherapy they practise. Interrogating the MSk dataset for evidence of similar practices has challenged my assumptions about what I thought I had seen being practised during my fieldwork. Through this analysis I have noticed that each group of therapists is accomplishing similar group identity outcomes through the use of interactional practices that suit the needs of the local group and their ‘tools to hand’. In the next section I reverse the analytic process and discuss the practices I first noticed in the MSk dataset and explore their relevance in the context of the neuro placement.

6.4 The ‘hows’ of the Musculoskeletal placement

Readers will recall that, as I began writing Chapter 5, I was starting to recognise emerging interaction practice patterns in the data and that, to some extent, the ‘hows’ of the practices and the work they performed have already been discussed. In this section therefore I follow the students in their 1:1 PEd interactions and attempt to slice the data in Chapter 5 in a different way. The emergent categories of practices identified in Table 6.1 provide the structure for this section. I describe each category in turn, discuss its emergence in the MSk data and then test out the ideas that arise from the analysis in the neuro dataset.

The most striking physical interaction practice I witnessed in the MSk context was the students’ walk away from their patients for discussion with the PEd. Analysis of the MSk dataset suggests that these away-from-patient debriefs were the cornerstone of the MSk education experience and influenced (or at least offered affordances\(^\text{10}\) for certain forms

\(^{10}\) Please see Appendix 5 for a discussion about my use of the term ‘affordance’
of interaction practices in both the subsequent student: patient and student: student interactions. I start this section with an analysis of the forms and execution of interaction practices in this patient-absent setting.

i) The Placement Educator-led student debriefs

Chapter 5 identified three forms of consistent interaction practice taking place in PEd-led away-from-the-patient student debriefs: participant spatial orientation to each other and about the patient’s notes (Figures 5.8 and 5.19); the PEd’s use of language (Figures 5.9 and 5.19); and the PEd’s use of touch (of the student’s notes [Figure 5.8] and body [Figure 5.11]). Throughout Chapter 5 I explored the resonances between the interaction practices I observed and those described in the established sociological literature. Drawing on the ideas of Trede and Higgs (2008) and Lynch and Macbeth (1998) I suggested that the MSk PEd team prioritised a hypotheticodeductive (HDR) form of clinical reasoning that was underpinned by a discourse of science and a patient absent model of healthcare. Further, I suggested that the need to collect data suitable for HDR based debriefs influenced the students’ interactions with patients. Using kinesics and proxemics data I illustrated practices by which students appeared to control their patients to facilitate the collection of HDR appropriate data. In turn these data, in the form of an immutable mobile (Latour 1990), were described as the centre of attention for the subsequent PEd led debrief. I concluded the chapter by suggesting that the observed forms of interaction practices worked together to promote HDR as the locally valued physiotherapy reasoning practice.

While I stand by my earlier conclusions, repeated analysis of both the MSk and neuro fieldwork datasets has helped me identify what Atkinson et al (2008) describe as a ‘contour’ or thread running through the seemingly jumbled mesh or web of practices (Gherardi 2006) performed in the MSk placement and acting as a motivator of the observed practices. The data sequences that record the students returning to their patients after their PEd debrief capture their consistent use of verbal expressions that convey both their own certainty (for example Figure 5.13) and allude to a presence from which that certainty is drawn (e.g. Figure 5.20). Indeed analysing student: patient dialogues from the patients’ perspective i.e. without the intervening PEd-led debrief, illustrates a shift in the students’ form of talk. At no time did a student verbally link their return to the interaction they had with the patient before they left the cubicle. Rather, the data records consistent use of verbal interaction statements that claimed their (the students’) ownership and pace of progression of the interaction. Analysis of the related
PEd debriefs suggests that the consistent linked PEd practice is the ‘you, I, we, you’ personal pronouns use sequence. I suggest that the students’ consistent verbal and kinesics practices on their return to their patients are an outward feature of the students’ perception of their endorsement as legitimate practitioners in this specific community of practice (Lave and Wenger 1991).

At this point the easy option would be to conclude by acknowledging the power of socialisation to drive a HDR patient-absent model of MSk physiotherapy and move on to explore the relevance of the ‘you, I, we, you’ sequence in the neuro dataset. However this neat cause and effect conclusion, by the very nature of its consistency, seemed unsatisfactory. While it had been helpful for me, the researcher, to have repeated patterns of multimodal interaction from which to evidence consistent practice and thus be able to suggest the underpinning discourses of this group of therapists, one might expect more variation in the way individual students conducted patient interactions. Adopting a more holistic stance to explore the MSk data, I schematised the typical placement interactions I observed (as illustrated in Figure 6.7) and the apparent lack of student individuality became more troubling.

Figure 6.7 represents the three elements of the MSk placement (core, duty, skills) and identifies the interaction participants in each setting. The interaction arrows suggest that the PEd is dominant in controlling the debrief interactions with their students, and that the students’ perceptions of the debrief interactions influences their interaction practices with the patients. The hashed lines leading from the patients (e.g. Pt1) illustrate their student-controlled input to the interaction. Representing the interaction players and directions in this way makes visible the distance of the PEd from the patient and the go-between positioning of the student. This finding challenged me to revisit the PEd-led debrief interactions and question if there was a practice I was missing that enabled them to effect control over the physically distant student: patient interaction. In addition, placing the two days of my fieldwork together in one diagram illustrated the absence of an observed PEd linking influence between the two days. Figure 6.7 thus exposed the troubles I was sensing. Given placement practices that distanced the PEds from direct involvement in the student: patient interaction, why did the data suggest practice consistency rather than students perhaps questioning the approaches they were adopting and developing personal patient interaction styles? And, if consistency was the root of my unease, what could it be that had this power to influence students’ interactional practices? Acknowledging that I am explicitly veering into a discussion about the ‘whats’ of the observed practices (Gubrium and Holstein 2000), I suggest that
the summative placement assessment – or more accurately the students' perception of that assessment – provides an explanatory link for some of the student: patient and student: student practices I recorded. I explore these ideas in the next subsection.

Figure 6.7: Schematic representation of typical MSk placement interactions.

The largest circle represents the two days of practices I observed. The consistent features of each placement are represented by the four smaller circles: two individual days of ‘core’ work with one, different PEd, and separate ‘techniques’ and ‘hydrotherapy duty’ sessions’. The smaller circles within the activity circles represent the interaction participants: placement educators (PEd), students (St 1 and St 2) and their patients (Pt 1 and Pt 2 respectively). The green lines linking the students’ circles from Core Day 1 to Core Day 2 acknowledge that the student is the consistent feature of each day’s practice. The directional black arrows represent my interpretation of the extent and relative participant control over interactions arising from my data analysis.

a. MSk student interaction practices explored through a lens of assessment awareness

As explained previously, the students’ eight placements are summatively assessed by placement educators with cumulative scores accounting for 28% of the students’ final degree classification. Throughout my data collection, and especially during their post-observation interviews, the MSk students spoke spontaneously about their perceptions of placement assessment practices. Sample extracts are collated in Figure 6.8.
Gareth: ‘I think I’m giving them opportunities to score me on the criteria… Clinical reasoning I think, they’ve really drawn out on the clinical reasoning, and “why are you doing that” and “why that and not something else?”. I think it’s obvious they are not looking to get a wrong answer, they just want to see how you are thinking about this. I found that really very helpful…. but well I don’t know explicitly what they want me to get out of the placement. I have a feeling that I know what they want me to be or what their overall picture is. And I think sometimes to be honest with you, that’s the kind of problem with this type of education.’

Louise: ‘It’s a lot about the SIN here, they love the SIN. Because whenever we come out from the patients, they are like “so what’s the severity?”, “what’s the irritability?”, they just want to know that. They want a lot of clinical reasoning, so say, I’ll be like, ‘well their posture is bad, they’ve got..’, so you’re just kind hypothesizing. So if you see something, what do you think it is, and what are you going to investigate, how are you going to test it. Which has really helped me, because I can do that now without being prompted, whereas at the beginning, I had to be prompted but that has really helped.

“Well I know that you put like your grades and stuff in your CV, yeah and your personal statement. I think you put it in somewhere, and I know John said that one of the clinical educators told him, on his last 2 placements if you get As in them, then you’re bound to get a job, but I don’t know how true that is because you’ll never really know. I think if someone sees that you’ve got quite a broad area of experience, then I think that’s quite good… because the assessment is a bit hit and miss…. I still get a good grade, but I could get a better grade if you had just told me how I can get better. I know we are doing well, but I don’t know what I’m meant to improve, and where I’m meant to go from here. It’s a bit airy fairy.’

In Chapter 5 I suggested that a thread linking the interaction practices I observed between MSk PEds and students was HDR, and that the ‘you, I, we, you’ verbal
sequences confirmed the students’ mastery of this locally valued thinking process, their ‘doing like being me-ness’ (after Garfinkel 1967) as it were. While this idea may have some validity, on its own HDR mastery does not explain the students’ lack of individuality when alone with their patients. However if we consider the students’ interaction practices with their PEds through a discourse of assessment, then the ‘you, I, we, you’ sequence is to the students, not recognition that they are becoming therapists, but that they are giving back to the PEd what the PEd who will be assessing them wants them to be giving back i.e. it provides confirmation to the students that they have spotted the correct placement assessment ‘mind game’ (Figure 6.8 Line 30) and are making good efforts at playing it. Edwards et al (2004) suggest that the step-wise data collection and associated thinking sequences evidenced in the hypotheticodeductive form of clinical reasoning makes HDR both easier to teach and learn than other, more narrative, forms of CR. Reading the data in Figure 6.8 suggests that, where summative assessment is perceived to underpin placement interactions, students value the explicitness of the HDR model but struggle when the ‘steps’ or emphases seem to be valued differently by different PEds (e.g. Lines 7-8, 26 and 29).

The MSk PEd: student debrief interaction thus creates affordances for students’ subsequent interactions with each other and their patients (Gibson 1977). As discussed in Appendix 5, Sharrock and Coulter (1998) suggest that affordances rely on the perceiver to see and understand their relevance and potential. Further, Schutz cautions social scientists to recognise that, while meaningful participant action is ‘motivated in terms of a preconceived project’, each interaction participant has chosen whether to comply or ‘drop’ the socially derived and apparently approved practice complicit in that project (1973, p. 145). Having identified the ‘assessment game’ as a possible motivator for the MSk students’ interaction practices, an awareness of the ideas of affordance perception and action choice will inform my analysis of student: student and student: patient interaction practices in later sections of this chapter. Before moving to this analysis I return to the neuro dataset and revisit the PEd: student away-from-patient-interactions. I begin with the pre-contact briefings.

b. Neuro PEd: student pre-contact briefings

Figures 6.9a and 6.9b are representations of the typical lifecycle of activities that surround each new patient assessment in the neuro ward (Figure 6.9a) and outpatient (Figure 6.9b) settings. The most obvious difference in PEd: student interaction practice between the MSk and neuro placements is the co-presence of the PEd and student
Figure 6.9a: Schematic representation of the typical ward-based physiotherapy patient interaction pathway.

- **Referral from ward Dr**
  - Database written from medical and nursing records; student led

- **Pt**
  - Enter pt's space
  - PEd led data collection and treatment phase as one
  - Numerical data written on hand/glove
  - PEd led Feel/touch/look/mvt data practice and discussion. No record

- **Pt's bed space**
  - PEd led verbal debriefs re findings, relevance, implications, plans
  - Student led note writing
  - PEd led note signing off

- **Shared ward space**
  - Allocating units

**Timeline**
- 5 mins lone
- 5-10 mins lone
- 40-50 mins
- 5 mins
- 20-25 mins lone (or with others nearby)
- 5 mins

**Total sequence c 100-110 mins**
**Contact time c 40-50 mins (45%)**
Figure 6.9b: The typical outpatient based physiotherapy patient interaction pathway.

Pt enters physio space

Referral from GP / physio / Medics

PEd led planning pt encounter using diagnosis on referral

PEd led pt assessment. Subj notes written in real time Obj pt findings discussed / translated over pt: no record

Pt leaves physio space

PEd led verbal debriefs re findings, relevance, implications, plans

Student led note writing

PEd led note signing off

Neuro outpatient office space

Timeline

5 – 30 mins

60 mins

5 mins

15 mins

5 mins

Total sequence c 100-120 mins
Contact time c 60 mins (50%)
throughout every patient contact. The verbal practices that occurred between the PEd, student and patient and the possible effect of those interaction practices on both the students’ learning and the patient’s autonomy have already been discussed. Here I interrogate the neuro dataset for evidence of consistent interaction practices in the PEd: student pre-patient contacts.

Figures 4.3 and 4.4 record pre-patient contact briefings in the ward and outpatient settings and illustrate two consistent features. Firstly the PEd talks the student through the assessment practices they are likely to employ in the imminent patient interaction. This verbal practice is reminiscent of the ‘positioning and disciplining witnesses’ that Lynch and Macbeth describe in their ethnomethodological observation of elementary school science classes (Lynch and Macbeth 1998, p. 277). Lynch and Macbeth describe this first phase in the teaching process as the teacher’s attempts to bring to the student’s mind the observation skills and associated language with which to describe the forthcoming science experiment – which, without such mental preparation, may not look like a science experiment at all. Analysing the pre-contact neuro PEd-led student briefings suggests that the PEd is using the interaction to affect a ‘concerted ordering [of the student’s] eyes, ears, hands, entire bodies and discursive actions’ (p. 277).

Secondly, the data record the PEd signalling to the student that they know the patient interaction is a learning event for the student and that they (the PEds) will support this (for example by ‘doing’ the assessment while the student observes in Figure 4.3a Line 8; or because they have worked with this specific student on this issue before as in Figure 4.3b Line 3; or by writing a crib sheet for the student in Figure 4.4 Line 17). These two forms of preparatory interaction locate the imminent patient interaction in the locally valued discourse (after Lynch and Macbeth, 1998), and ‘confers legitimacy’ for the student to join the PEd in the shared endeavour of their work (Lave and Wenger 1991, p. 92). While the PEd’s description of the phases of the patient assessment is similar to that used in the MSk context (e.g. Figure 4.4 Lines 16-17), the neuro pre-contact briefings appear to be preparing the students for witnessing a different form of therapist: patient interaction.

Returning to Figures 6.9a and 6.9b we see the PEds and students concluding the briefing by applying hygiene control measures, and heading to the patient. After the patient has left (Figure 6.9b), or been left (Figure 6.9a), the therapists repeat their hygiene control practices and regroup for their post-patient contact PEd-led debrief.
c. Neuro PEd: student post-contact briefings

Figures 6.9a and 6.9b illustrate that neuro post-patient debriefs occur in two short PEd-led phases which frame a period of student note writing. Analysing each phase of the debriefs separately suggests that the purpose of the first interaction is for the PEd to confirm that the student has understood and can verbalise what they observed, felt and discussed in the presence of the patient in the way the PEd expects. In Figure 4.12a and 12b for example the PEds Amelia and Lucy use words like 'co-contraction', 'stimulus', 'trunk alignment' etc. which appear to replace the MSk PEd emphasis on 'SIN factors', 'objective markers' and 'hypothesis' (Figures 5.10 and 5.18). The perceived difference in focus for a neuro assessment is made explicit in Figure 4.12a Line 7 when Amelia (the lead neuro PEd) directs Verity to think with 'more of a neuro emphasis'. Such verbal practices are reminiscent of Lynch and Macbeth's science teachers both 'securing and shaping' the students' descriptors of what they have seen (p. 282) and helping them learn to account for what they have done to the patient in ways that 'upgrade the common sense explanations' (p. 284) for the body work they have just performed - to make it a special case of physiotherapy work as it were (after Sacks 1984; Twigg 2000).

When the students have attempted to write the patients' record, the PEds return for a second period of debrief. Analysis of these interactions illustrates further consistent verbal and proxemics practices. Firstly, as in both Figures 4.16 and 4.18, the PEds physically touch and ‘gaze’ at the notes the students have written. Through these nonverbal practices the PEds appear to turn the students' notes into the 'machinery of seeing' (Amann and Knorr Cetina 1990, p. 90) or a tangible resource about which the verbal elements of the interaction hang. This observation is reminiscent of the MSk PEd-led debriefs in Chapter 5. In the MSk context we saw PEds walking their students verbally through linear HDR 'steps' and, I suggested, confirming the students' developing thinking practices as locally acceptable through the use of the 'you, I, we, you' pronoun sequence. In Figures 4.16 and 4.18 the neuro PEds use similar pronoun sequences but with more PEd use of the personal pronoun 'I'. Thus in Figure 4.18 Line 15 Lorna uses the expression 'So if I were you, I would go…' while in Figure 4.16 Line 11 Julie says 'So I would write the objective like this.' These neuro practices of embedding in talk how locally valued 'seeing' practices are interactively accomplished resonate strongly with Amann and Knorr Cetina's observation of scientists at work in laboratory settings (1990, p. 90), but differ from MSk practice because the neuro PEds have seen, felt, smelt and talked to and over the same patient as the student. The neuro PEd-led student debriefs thus work to develop the students' ability to think and write
about patient contact in the way each PEd would do it. This distinction is important given discussions earlier in this chapter about student agency and the role of the PEd in influencing a certain form of student learning.

As illustrated in Figures 6.9a and 6.9b, each 100-120 minute ward- or outpatient-based neuro patient contact cycle acts as one coherent event. Within this event direct patient contact accounts for 45-50% of the time with the rest used by the PEd to teach the students to reproduce their (the individual PEd's) accounting practices. Unlike their MSk peers, the neuro students are only away from their PEds for periods of lone pre- and post- patient contact not writing. With each of these written entries checked and discussed by the PEds, the neuro students' opportunities for individual agency appear limited. While Isobel for example in Figure 4.16 discusses her ideas about the patient with her PEd, it is, quite literally, Julie who holds the pencil (Sketch Line 14) and decides what of their conversation will make it into the written record (Lines 19-20).

Analysis of the neuro data thus suggests that the away-from-patient PEd-led student briefings and de-briefings are performed differently from those of the MSk placement but to similar effect: the students' learning of locally valued accounting practices that prioritise patient-remote note writing and treatment planning practices. In both the MSk and neuro settings, successful reasoning / accounting performances are facilitated and rewarded by verbal expressions, physical touching, head-nodding and smiles that confirm the students' legitimate participation in the work of the local group of therapists (Lave and Wenger 1991). The question that remains is whether there is evidence in the neuro dataset that students' perceptions of placement assessment influence their interactions with their PEds and patients.

d. Neuro student: PEd interaction practices explored through a lens of assessment awareness

Figures 6.9a and 6.9b suggest that in the first week of a neuro placement students were only away from their PEds for periods of note writing. Analysing how each student spent this time in the ward setting illustrated consistent, silent practices with students apparently oblivious to the bustle of ward life going on around them. The exception was the interaction between Gareth (the Band 5 neuro therapist) and Isobel (recorded in Figure 4.18 Lines 25-35) in which he explains local note writing expectations. In a few short sentences Gareth lists the process while Isobel takes personal notes in a small notebook. Remembering that Isobel's ward-based PEd, Lorna, did not verbalise her
therapeutic practices in the presence of her patients, the interaction demonstrates agentic practice, Isobel's choosing to take the initiative and ask for help to clarify a process. In this section I discuss why I think Isobel's practice here is evidence of her assessment awareness. Figure 6.10 collates representative short extracts of spontaneous student-generated lunch-break conversations about assessment I recorded in my field diary, with related extracts from Verity and Isobel's post-observation interviews.

Figure 6.10: Neuro students reflecting on their neuro placement learning

Verity:

i) **Snippets of lunchtime comments Day 1:**

1 ‘Oh it’s so hard. All the time trying to pick up on things they seem to want as quickly as you can. It is like they want us to become like them. It’s hard and even worse when they don’t seem to agree.’

ii) **Related interview extract:**

4 ‘But I think it’s such a big thing in how you enjoy a placement and who are your clineds, I think it is so much to do with how approachable your clined is, how much knowledge they have and how experienced they are in what they are doing. And then generally just wanting the student to be there, just wanting them to learn and wanting to teach them stuff. ...on other placements I found it really hard to get my knowledge across and just kind of blurt out with like “the epidemiology of this disease is”. Because it’s in the marking. (CK: yes...) But then I want them to ..know that I do know and that I do care about the subject

Um... They said to me this week at the start, said just to think more laterally about the patients on the wards, just about other treatments that you can do and not just what we’ve been doing. And I’ve tried to but a lot of the time my ideas are the same as hers so it just looks like I haven’t got any new ideas but I’ve tried to be a bit more ... lateral as she said. With the patient, she’s a dyspraxia patient and she’s got really tight upper traps and she just holds her right ear to her right shoulder. So we can try and give her a stretch and if she’s in pain she brings it back. I said today actually why don’t we tell all the nurses and everyone who sees her, to come to her left shoulder and so she has to turn around and look at them so it’s a stretch without her knowing, so feeding her from her left side and things like that. And they said that that was alright so I don’t know if that was lateral thinking in her mind, but.. I gave it a good go. Sometimes it’s hard to know whether you’ve done enough, you want to say “did I laterally think then” or “do I need to do more”.

Isobel:

i) **Snippets of lunchtime comments Day 2:**

26 ‘In my last placement I did lots of work but never found much opportunity to say, so when it came to my grade I missed a grade because of it. I was really frustrated because I had done the work, so then I realised that my grade is in your hands, and I make a point now of asking how they want me to show them things… It’s hard here though because they seem to want different things. Downstairs I can talk ideas through like I am one of them, but upstairs I have to reel 10 things off, and if they’re not what they are thinking they will keep on until I come up with it. I’m not rewarded for what I’m saying if it’s not what they want.’
Related interview extract:

‘I don’t really know how they are going to grade me because I’ve not really been, you know half and half [referring to ward / outpatient split]. If I knew who was coming here next I’d say... I would tell them to be very confident about their decisions and their treatments, specifically on the ward because it needs to come across. There’s not an opportunity to talk about things, so you need to show immediately, whether you don’t really know what’s going on or not, it needs to come across like you do. You’ve got to show that person that I know what I’m doing right now. …if I was to do it again it doesn’t matter what anyone else is doing, you’ve got a job to do, just do it.’

The similarity between the issues raised by the neuro students in Figure 6.10 and their MSk peers in Figure 6.8 is striking. Analysis of the neuro dataset generates the following discussion. Firstly, both students in Figure 6.10 articulate the tension they perceive between wanting to learn and knowing that they are being summatively assessed (Lines 7-11 and 26-28). Although Verity appears to be reluctant (Lines 10-11), assessment performance is the lens through which both students report approaching their interactions with their PEds (Lines 1, and 38-41). Verity and Isobel’s self-reported practices resonate with Goffman’s ideas (1969, p. 3) about the ‘presentation of self in everyday life’ as they describe the strategies by which they try to control (or at least influence) the conduct of their PEds to positively reinforce their practice and assess them favourably.

Both students describe how, in the early days of their placement, they try to predict what it is that their specific PEds want, and then develop practice strategies and create ‘showing’ opportunities despite these feeling awkward and temporally inappropriate. Isobel’s use the expression ‘you need to show’ (Lines 38 and 40) suggests that she is specifically ‘mobilising behaviours… to fit into the understanding and expectations of the society in which it is presents’ (Goffman 1969, p. 30). Further, Verity recognises the importance of having an experienced clinician as her PEd (Line 6). While the assessment-related practice insights offered by the students in Figure 6.10 cannot be confirmed explicitly in my data, they do offer an explanation for Isobel’s practice of seeking note writing guidance from Gareth. Viewing Isobel’s intra-team interactions through a lens of ‘impression management’, we can see them as a dramatic realisation of the affordance she has seen – and grasped (Goffman 1969, p. 71). In an environment where students have very little opportunity for individual agency (Figure 6.10 Lines 14-16) Isobel has demonstrated her ability to define the situation, spot the gap in her understanding and find someone with no dramaturgical control to help develop that understanding in order to enhance her performances to Lorna (Sharrock and Coulter 1998).
e. Tracing a thread through the maze of PEd: student interaction practices

I have used the ideas of affordance, assessment perception, personal agency and impression management to analyse and discuss the wealth of consistent practices observed between MSk and neuro PEds and their students in patient-absent interactions. This section has challenged me to revisit assumptions about the possible interdependence of PEd verbal and nonverbal practices and subsequent observed student performances. In so doing I have noticed that, while the interaction participants perform recognisable and consistent interaction practices, each ‘type’ of performer is playing his / her role with a different underpinning motivation. Exploring these ideas further is fertile ground for future research and resonates with Bernstein’s ideas about the impact on learning of so-called visible and invisible pedagogies (1975). Bernstein described pedagogy as visible when the curriculum was ‘realised through strong classification and strong frames’ (p. 23) or clearly defined teaching / learning strategies and aligned assessments. An invisible pedagogy is not the antithesis of the visible, but rather is differentiated by the less explicit / visible ‘manner in which criteria are transmitted and in the degree of the specificity of the criteria’ (Bernstein 1975, p. 23).

Bernstein’s ideas were developed in the context of infant school education. Gherardi (2006) explored their relevance in the context of the education of construction work professionals. The construction apprentices she observed worked alongside the site managers in their daily work with little emphasis on knowledge transmission or the acquisition of specific skills. Gherardi concluded that workplace learning took ‘place within a community of practitioners according to an invisible pedagogy’ (2006, p. 128). If we consider that the daily reality of the physiotherapy students’ placement education experiences described in this thesis evidence an invisible pedagogy, then the tension or mismatch between the pedagogy of the learning environment and the visible, tightly framed, seemingly objective, placement assessment criteria becomes clear (Bernstein 1975). The potential for pedagogic tension increases when we remember that the assessment proforma and criteria are generic across all placements and have been developed by the academic department for application in local contexts. The data in this study suggest that physiotherapy students are alert both to the tension of a mixed visible and invisible placement pedagogy and draw on the regulatory rules (or assessment form and criteria here) to anchor their interaction practices (Bernstein 2000). In addition, as illustrated in Figure 6.10, the students recognise from previous placement experiences that the assessment proforma and criteria are locally recontextualised and thus focus
their early placement attention on understanding the ‘habitus or taken-for-granted aspects of everyday life’ at this site (Gherardi 2006, p. 125).

The suggestion that students and PEds have different early placement priorities resonates with another theme arising from the data in Figure 6.10: the notion of ‘time’. Roth uses the term ‘career timetables’ to refer to the mental timeline of activities and progress norms that individuals create in most situations as anchors of their expectations of how the related activity will progress (1963). Here I consider the evidence that PEds and students have different internal placement timetables.

Two expressions in Figure 6.10 suggest the presence of a consistent student timetable: in Line 1 Verity describes the need to orientate to locally valued performance practice ‘as quickly as you can’ and, in Line 38, Isobel describes the same idea as the ‘need to show immediately’ (Line 38). These phrases suggest that students, alert to the relevance of early impression management to their summative placement score, perceive urgency in their internal referencing of the four week placement.

Readers will recall that the neuro PEd team gave each student a list of weekly tasks (Table 4.2) and were heard liaising to provide the related opportunities to practise these in the relevant weeks. These weekly ‘objectives’ appear incremental and worded to reflect the learning outcomes for neurology placements. If we consider the objective list to indicate the local neuro PEds’ conception of the four week placement, we can sense a placement that is paced evenly and focussed about learning experiences that resonate with the PEds’ verbal placement aims.11 But there is a sense too of a mismatch between the PEds’ and students’ timetables or internal perceptions of placement emphasis and outcome. Roth identifies interaction participant timetable ‘conflict’ as a major source of interaction dissonance (1963, p. 31). In his study of patient, doctor and nurse interactions in a TB hospital setting, Roth describes the ‘surprise’ and ‘irritation’ plain on the doctors’ faces when they felt their interpretation of a patient’s hospital stay timeline was being questioned (p. 41). In scenes remarkably similar to those recorded in my data, Roth describes the offending patient (or here the student) getting ‘noisily agitated’ when the timetable conflict became apparent. Further, where there was no scope for interaction participants to make allowances to understand the timetables of the

---

11 Readers will recall how, in my access interview, the neuro PEds described the main aim of their placement as being to ‘give them the confidence… get them to have a go… and get the confidence that they can do it’ (Figure 4.1 Lines 9, 26-27).
other, the dissonance persisted with labels of ‘good’ (and one assumes ‘bad’) associated with the mutually offending party (p. 38).

To draw this section to a close I suggest that the organisational and personal interaction practices of the neuro and MSk PEds reflect their stated placement aims, but in a summatively assessed learning environment underpinned by an invisible pedagogy framed in a four-week placement, the students have developed an internal placement timetable, based on their previous placement experiences, which privileges early impression management. The consequences of this potential mismatch in timetable perception and an exploration of their relevance to a patient’s therapy timetable will be discussed in later sections. For now I return to an analysis of the MSk dataset to discuss the MSk affordance for student: student interaction.

ii) MSk student: student interaction practices

In Figure 6.7 a hashed bidirectional line runs between the circles representing the two students to summarise the MSk student: student interactions that I discussed in Appendix 6. The discussions in Appendix 6 suggested a mismatch between the PEds’ expectations of student peer-learning and the reality I observed. In practice the fieldwork data recorded minimal peer interaction (either social or work related) during the timetabled shared hour, with individual reading and personal palpation being the dominant activity (see for example Appendix 6 Figure 8). In Appendix 6 I suggested that the consistent absence of peer assisted learning (PAL) reflected the students’ inability to notice or use the affordances of the timetabling because, early in their placement as it was when I observed them, they still needed guidance to practise locally valued skills and reasoning practices. Re-analysing the data I recognise that this explanation is problematic given that the students were third years with experience of at least one previous MSk placement.

If we view the ‘hows’ of the student: student interaction practices within the context of a ‘what’ as a preconceived project motivated by impression management and assessment achievement, the consistent absence of PAL becomes more expected. It is widely documented in the mainstream higher education literature that assessment, or rather students’ perception about the demands of their assessment, influences the approach to learning that they adopt (see for example Ramsden 1992; Tang 1994). Learning approaches are thus recognised as malleable and context dependent. Reflecting on the form of placement assessment and the MSk students’ perceptions about its fallibility
(see Figure 6.8 for examples), it is likely that the students recognise a misalignment between learning opportunities intended to foster PAL and assessment based on individual performance, and interact with each other accordingly. During my third period in the field I was sensing the possible interaction practice consequences of students effectively jousting for their PEd’s attention and raised the PAL potential of the placement in my post-observation interviews with Louise and John (who were co-placed on placement 3). Figure 6.11 collates the students’ responses.

Figure 6.11: Students’ reflections of the placement sharing experience

| Louise: ‘I like it because I think I'd feel quite lonely if John wasn't there, because you're not really part of the team, and I'd think I'd notice it a lot more if he wasn't there. And I think I wouldn't enjoy it as much. We kind of like, I'll be like “oh you've had an ankle patient, can you give me some ideas”. And also John came out yesterday and said “I've got this back patient, what else can I assess?”: So I like gave him my ideas, and he was like “oh yeah”. I think it's quite nice in that way.’ |
| John: ‘It's hard to try and work out what's going on. I think here having 2 students together, regardless of who they were, I think is hard to try and simulate yourself into things and into a team because you're with someone else for quite a lot of the time, and you're seen as like “the students” because there is a pair of you. … And I find that having Louise with me is quite difficult, it's not because it's her, but it's having someone else, I can't be myself, and start talking about all of the things that I've done. The first couple of weeks as well, I found it really weird how probably up until (I don't know) even this week, none of the clinicians would ever look at me when they were talking to me and Louise, they'd always be facing Louise, and they were directing the questions to her, and I would be there trying to mirror their body language, trying to make eye contact, trying to get body language, trying to get involved, trying to get engaged, and I was never ever getting any interaction, I get a look over but then they will look at Louise. Me and Louise have talked about this and it's pretty strange, but it doesn't affect her because they are asking her, so she doesn't really notice until I point it out, and she'll be like “oh yeah”… and I'm just a spare part’. |

A caveat to a close reading of the different perspectives of experiencing the same MSk placement in Figure 6.11, is the recognition that John, a mature student with a degree in anthropology, may have been using the interview as a ‘remedial interchange’ to account for placement experiences arising from a plethora of origins (Goffman 1972, p. 221). Notwithstanding this cautionary note, Figure 6.11 suggests very different perceptions of PAL experiences. While Louise appears to have had a positive shared placement experience with John providing both company and sounding-board advice, John’s extract suggests a different perceived experience. It is notable too that Louise made no further reference to John, his impact on her placement or concerns about his own placement experiences in her interview, while John referred frequently to his perception of the shared learning environment on his placement experiences.
The difference between the students’ talk about the impact of a peer on their individual learning experiences in Figure 6.11 suggests the existence of an implicit internal student hierarchy that effected both the student: student and PEd: student interaction practices. A personal motivation to achieve in the individual placement summative assessment may be a factor in the origin of this internal hierarchy. This orientation to an individually motivated goal is evidenced by the interaction practices students adopted when their individual patient-contact practices (those that generate the data for their PEd-led debriefs) intersected with that of their peer. In Figures 5.1 and 5.2 we saw Louise and Emily gaining the PEd’s attention in their brief PEd-led preparation for a new patient assessment. The significance of ‘getting ahead’ in a timed patient contact session where two students are undertaking assessments simultaneously is illustrated in Figure 6.12.

Figure 6.12 has been created by analysing the data for new MSk patient assessments across my dataset and is thus representative rather than unique for a specific event. The Figure comprises two elements: a large upper map tracking the interactions between each student, the PEd and the patient, and an accompanying indicative timeline. The interaction map illustrates subtle, but important, differences in each of the students’ (and consequently their patients’) experiences. In common with the neuro practices we saw in Figures 6.9a and 6.9b, the full MSk new patient assessment cycle depicted in Figure 6.12 requires the students to engage in a sequence of interactions. The student: patient interaction accounts for c. 44% of the time available for the student to complete the full sequence of related activities. While Figure 6.12 suggests that both students’ patients are in the department for a similar time, analysis of the interaction map of the second student suggests that their patient waits longer, and thus has less contact time with the student, than the patient whose student grasped the attention of the PEd first. In addition, the map suggests that the second student is placed at a time disadvantage that extends beyond the allocated contact time for the specific patient and into the preparation time for their next.

The possibility that students compete for the attentions of their PEds is another outcome from this current study that could be explored in future research. Here, drawing on the limited data I have, I can only note that, in Figure 6.11, John’s talk conveys a sense of

---

12 I am also aware that my presence may have influenced the internal hierarchy, at least on a temporary basis. In each set of field data the student I was shadowing was consistently the ‘first’. I have therefore not experienced the waiting and potential time-catch-up strategies that ‘the second student’ must perform in order to collect the data required by the PEd for a successful performance of HDR within the confines of a diary-operated patient contact system.
Figure 6.12: Schematic representation of PEd: student: patient interactions when students have simultaneous new patient assessments.

Timeline | 1 min | 15 mins | 5-10 mins | 15 mins | 5-10 mins | 10 mins | Max 30 mins
--- | --- | --- | --- | --- | --- | --- | ---
Total sequence c 90 mins
Patient contact c 40 (44%)
resignation that he has been placed (or been beaten into being placed) in the second student or 'spare part' role (Line 22). If the MSk students' interaction practices are evidence of their alertness to the local practices of placement assessment, the only opportunity for the second student to control their impression management is during their PEd: student debriefs. Conceiving interaction practices as informed by personal agenda or timetables, I suggest that, in a placement where the organisational and assessment formats and individual local PEds' practices promote a 2x1:1 placement, there are four individual timetables at work in the field of practices simultaneously: one PEd, one patient and two students. In addition, the daily PEd change (Figure 6.7) means MSk students have to work out and apply the subtleties of three distinct expectations and interpretations of their performance progress against the assessment criteria. In a context of multiple perceptions, expectations, and potentially counter expectations, the students appear to be anchoring their interaction practices with their peer around the, perhaps only, visibly shared PEd practice: the local accounting practice of sequential HDR (see for example Figure 6.11 Lines 4-5).

In the next subsection I complete my discussion of the practice categories arising from my analysis of the MSk data (Table 6.1) with an exploration of student: patient interactions.

iii) Further discussion about student: patient interactions

Figure 6.12 makes visible the context within which the interaction practices between MSk students and patients described in Chapter 5 were observed. In this subsection I draw out and analyse the interactional practices that I observed 'my' MSk student performing in their patient contact sessions. I will then test out the ideas arising from this discussion in the neuro dataset where there was only one student on placement at a time.

Consistent student interaction practices were visible in the MSk patient contacts, specifically:

- Figures 5.6 and 5.13 illustrated students' use of verbal, proxemics, tactile and kinesics-based interaction practices that appeared to manage (or control) their patient and generate HDR appropriate data (Latour 1990; Lynch and Macbeth 1998);
- Figure 5.12 described their use of combined proxemics and kinesics practices to disattend to their patient's clothing removal (Emerson 1970; Twigg et al. 2011);
- Figure 5.20 Line 16 illustrated the "embodied action" (after Heath and Luff 2012) by which students drew the consultation to a close, and
- Figures 5.12 and 5.20 drew attention to the absence of interaction practices that might help the patient locate the purpose and expectations of the phases of their contact time with the student.

The consistency of the MSk students’ performance (and omission) of these practices is notable because I did not see the students either observing each other or their PEds to learn such practices directly. Analysis of the MSk field notes and the data in Figure 6.12 resonates with Schutz’ observation that meaningful action, motivated in terms of a preconceived project, takes place using the resources ‘actually to hand’ (1973, p. 145). Given our earlier discussions about the multiple contextual issues potentially influencing the students’ notion of a preconceived project and associated performance timetable, it may be that the students’ consistent interaction performances have evolved by force of circumstance to effect each patient interaction as efficiently as possible.

Returning full circle to our discussions at the beginning of this Chapter, and cognisant that I am only drawing on ‘first’ student related observations here, an analysis of MSk student: patient interaction practices suggests a link between the PEds’ practice in the PEd: student debriefs and those of the student in their interaction with patients. I suggest that the link is determined by the students’ response to the affordance for individual agency provided by the organisational structure of the placement that distances the PEd from direct student-present patient contact. The student: patient interaction is thus influenced by the students’ interpretation of the placement timetable. The data in Figure 6.8 and Chapter 5, suggest that, where the MSk students appear to be motivated by a concern for their summative placement assessment, their patient contact practices are led by a preconceived project to make a good showing to their PEd (Goffman 1969). The resultant MSk patient-contact interaction practices demonstrate an absence of the students’ consideration of the patient’s perspectives of their condition and associated therapeutic timetable (Roth 1963). But does this hold true for the neuro student patient encounters? To draw this subsection to a close I test out these ideas in the neuro dataset.

While neuro students did not undertake lone student: patient interactions at the time of this study, they were privy to, or co-practitioners in, interactions led by their PEds. Three forms of patient-present, PEd-led interaction practice have been discussed elsewhere in this thesis: verbal (Figures 4.5, 4.8 and 4.9b), touch/physical (Figure 6.1) and embodied action based (Appendix 3 Figure 1).
Readers will recall too that the neuro PEds enacted two forms of verbal practice with patients in the presence of their student (silence or turning the patient into a real time audio-visual teaching aid) and that these practices appeared to be linked to the PEd’s speciality-relevant expertise. Figure 6.13 exemplifies this and other verbal practices which, resonating with ideas arising from data analysis earlier in this chapter, suggest a mismatch between the patient’s and therapists' interaction rationale perceptions or ‘timetables’ (Roth 1963).

Figure 6.13: Typical over the patient experienced PEd talk to a neuro student

4.00pm Amelia and Verity repeating a muscle test on a patient with an improving muscle weakening condition.
1. Amelia and Verity discuss scores and which muscles to choose, which to ‘leave out for now.’
2. Amelia explaining link between tests and myotomes (Verity lets her although I know Lucy did this with her this morning too!);
3. Amelia talking about left leg movements: ‘At the hip we could… but not entirely accurate as can’t do it in this position… but I think there’s no need.’
4. Pats pt’s leg as she talks about scores to Verity. Keeps almost constant contact with some part of pt’s body.
5. 4.15 pm Pt listening ++
6. Pt: ‘That’s a big improvement.’
7. Voice appears to come out of the blue as Amelia and Verity happily discussing the legs they are both focussed on.
8. Amelia asks Verity to have a go at some of the leg assessments.
9. Verity gives pt clear instructions, but no support of limb to take weight for pt. Can clearly see that she is not working with what the patient has;
10. Verity and Amelia discuss scores;
11. Amelia to Verity: ‘She may be able to… you will need to…’
12. Amelia to pt.: ‘We are just going to…’
13. Verity does. Big discussion about score: is it a 3 or a 3+? Should they use a ‘+’, ‘Where some clinicians would not use it.’
14. Moving on, Amelia corrects Verity’s handling to ensure that her hands are over the muscle being tested;
15. Verity gives pt a very complicated instruction. Amelia simplifies. Cycle repeats
16. 4.20 pm Amelia to pt.: ‘Apologies Y, as we are running out of time we will have to leave your stand until tomorrow. We have come to the end of the day, so standing is a priority for tomorrow.’
17. Pt seems upset: ‘Oh oh, OK then.’

In Figure 6.13 Amelia (the experienced PEd) and Verity are re-assessing a patient’s muscle strength. Several features of this PEd-led scenario suggest that Amelia’s verbal interaction practices are motivated by her own rather than her patient’s concerns. In Line 17 Amelia uses the word ‘she’ to draw Verity’s attention away from the person on the bed and focus instead on the patient’s limbs. These limbs became the resource, or artefacts of the educator’s and student’s shared work (Goodwin 1994; Strong 2006b). In Lines 9-20 Verity
learns to feel and talk about these artefacts like a neuro physiotherapist (Rose 1999). The distance between a consideration of the patient’s motivation for consenting to the therapeutic interaction and its reality is evidenced further in Line 10 when the patient’s voice enters the PEd: student discussion. One can assume that, for a blind, bed-ridden patient, any sense that she is improving would be important for her to hear and place in the context of her broader illness timetable. Amelia’s quick return to her teaching activity resonates with Strong’s observations of doctor: patient interactions when ‘the audience effect’ (p.163), induced by having students present, turns the patient into ‘an empirical instance’ to be ‘taught from’ (2006b, p. 167). Finally, Figure 6.13 Lines 25-27 provide evidence of another source of timetable conflict: the length of the official working day. Notwithstanding the obviously different over-the-patient talk practice of the experienced PEds, analysis of running sequences of all the neuro PEd: patient interactions observed by students suggests that students witnessed verbal practices that appeared to manage patients’ responses for the PEds’ purposes.

Throughout this thesis touch and body work (the use of therapist's own body to facilitate the movement of their patient) have been identified as the core work of neuro therapists. Re-analysing the neuro PEd: student: patient touch-based data in the context of verbal interaction practices motivated by patient-absent agenda, suggests that touch is also used to control patients’ physical interaction. In Figure 6.1 for example, the therapists have the patient surrounded and, through their combined verbal and touch-based practices, require the patient to move in a certain way at their (the therapists’) direction. The thought that the contact event is being staged for purposes not owned by the patient is uncomfortable for me as a former neuro therapist. Further research is needed to explore patients’ perspectives of therapeutic interactions and extend Jorgensen’s earlier work (2000). In this subsection I have shown how analysing both the MSk and neuro datasets has provided a plethora of evidence of therapists (students and PEds) using multiple interaction practices to control patients’ contribution (both physical and verbal) to that interaction. In both the neuro and MSk placements, students experience patient-related education events where the patient is only present for 44-50% of the time. The consistent practices of therapist: patient interactions observed in this study illustrate patients performing a role in someone else’s career timetable.

The consistency of patient-contact practices observed across placements is notable when one remembers that the MSk students did not observe or co-work with their PEds in order to learn practices relevant to this specific placement. I suggested, earlier in this chapter, that patient controlling practices were enacted in response to the MSk students’ perception of the
local interpretations of the placement assessment criteria and created from the opportunities to hand i.e. their verbal, kinesics and proxemics based interaction practices. In this subsection I have drawn attention to neuro PEd interaction practices that affect patient interaction in similar ways. While the minuitae of the performance of these interaction practices differs between the placements because of the work being performed, the underlying consistency, and seeming invisibility of their presence to staff and students alike, suggest they are external manifestations of the practitioners’ shared ‘lebenswelt’: the common sense knowledge of everyday life (Schutz 1973, p. 133). Noting that the MSk students had passed at least four placements with other therapy teams across the country before my fieldwork, I suggest that the patient-controlling practices I observed were ‘typifications of the common-sense thinking’ of physiotherapy ‘that constitute the... taken for granted, … unquestioned... social matrix’ of the broader community of physiotherapists (Schutz 1973, p. 57), and as a consequence were, at least in part, brought with the students from previous placements. A study of students’ practices on their first placement could explore this idea further.

Section summary

This section has analysed the MSk dataset to explore key interaction practices and tested the relevance of themes and ideas arising from this analysis in the context of the neuro dataset. Chapters 4 and 5 were written in different styles that reflected my data processing journey. This difference has influenced the approach adopted in this section. To avoid repetition, this chapter started re-analysing the MSk data with a sense of the ‘hows’ (Gubrium and Holstein 2000) already in place, progressed to consider some possible ‘whats’ of MSk observed practices and used the emerging threads or contours of practice to re-interrogate the neuro data. Collectively this section has evidenced a spiral analysis with ideas and themes being tested and re-expressed in each subsection. The interdependency of the threads of ‘whats’ becoming visible from this repeated analysis inform the data synthesis and chapter summary that follow.

6.5 Chapter summary: exploring the interplay between practice ‘hows’ and ‘whats’

The analyses and discussion of the rich, multimodal datasets which make visible the practical accomplishment of physiotherapy placement education throw some light on what the collective web of practices (Gherardi 2006) suggests about what it might be to do being occupationally ordinary within the neuro and MSk student-present physiotherapy teams at this hospital site (Sacks 1984). In this section I identify some ‘whats’ that appeared to inform
and shape the ‘hows’ we have observed (Gubrium and Holstein 2000). Gubrium and Holstein remind researchers to recognise the interplay or dynamic relationship between practice ‘hows’ and ‘whats’ to ‘avoid analytically privileging either … practice [the ‘hows’] or discourses-in-practice [the ‘whats’]’ (2000, p. 497). In the context of this study with its commitment to ethnomethodological ideas, the challenge is to make visible the methods of ‘practical action in situated use amongst members’ (Fox 2006, p. 442) rather than conceive learning as ‘some independently reifiable process that just happens to be located somewhere’ (Lave and Wenger 1991, p. 35). In this section I thus explore the interplay between the ‘hows’ and ‘whats’ by which social practices accomplish and produce the ‘sense of a setting’ (Fox 2006, p. 430) in the placement interactions I observed. Noting that my data were collected at specific points in the students’ placement experience, this section can only offer some contextual or group features that have influenced or been influenced by the interaction practices reported in this thesis. Before I draw the chapter to a close I discuss three interrelated groups of broad ‘whats’ that appear to affect the students’ placement learning experiences: the structural organisation of the local physiotherapy work; the physical nature of that work; and the educational practices by which that work is taught to students.

i) Structural organisation of physiotherapy work

The data explored in this thesis suggest that the work of physiotherapy observed and practised by students on placement at the study sites is structured and influenced by three co-existing frameworks: the space in which the therapists work, the internal structure of each therapy-focused interaction, and the broad working hours of each therapist. I discuss each element in turn here.

- **The work space.** The spatial placing of the therapists’ work appears to be linked to the ‘type’ of patient that the therapists and students encounter and to the therapy focus and work performed in that space. Chapters 4 and 5 located the work of the neuro and MSk teams in broad fields of patient diagnoses and this chapter has illustrated differences in some language use by the PEds which suggests that physiotherapists in each work space are interested in or creating their work from different aspects of their patient’s care needs. For example, the neuro PEds used language that appeared to draw students’ attention to the functional abilities (and disabilities) of their patient (Scully and Shepard 1983; Sim 1990), and the MSk PEds focused on hypothesis generation and the assumption that a ‘cure’ of the presenting problem could be expected (Lundström 2008).
However, we have also observed diversity within each broad work space: the neuro placement required students to move between ward and outpatient-based spaces while the MSk students moved between Departmental / cubicle-based settings and the hydrotherapy pool. This chapter has made visible how the peculiarities of each work space affected the interaction practices of the PEEds and students working with their patient in these spaces. Thus within the same group of therapists we have seen shifts in the minutiae of their proxemics- and kinesics- based practices in each setting. Within the neuro context for example, the spatial location of the patient influenced the subtleties by which therapists navigated the therapy opening and closing sequences, and similarly, within the MSk placement we have observed spatially-related changes in practitioners’ use of kinesics and physical contact as therapists moved from dry-land to water-based spaces;

- **The internal structuring of each patient-facing interaction.** Figure 6.14 summarises the distinguishable activities students performed in each placement setting and places them in the sequence in which they typically occurred. Figure 6.14 thus also illustrates the consistent phases or steps by which the PEEds structured the patient-facing elements of placements. While, as we have seen, features of the specific placement and the work within that placement influenced some intervening practices (e.g. hygiene control, uniform changing etc.), the pre-, during and post- patient contact interaction phases were identifiable across all contexts. We also noted that, with the exception of some students working in the hydrotherapy pool, the learners appeared to recognise and expect the interaction phases to be sequenced and structured as they were;

- **The temporal structuring of therapists’ daily work.** This chapter has drawn on the data setting out the everyday practices of the neuro and MSk therapy teams to explore the impact of time on both the organisation of therapists’ work and the positioning of the patient within that work. In both placement settings we have followed the therapists’ daily working timetable and recorded practice timelines and snippets of verbal communication between therapists that have indicated a need to complete patient-related caseloads in predictable and tightly framed time slots (neuro and MSk department-based work) or manage and record those caseloads within a context of unpredictable attendance (hydrotherapy) and patient health needs that effected both their ability to engage in physiotherapy sessions and the number of therapists required to support that session (neuro ward). Chapters 4, 5 and 6 evidenced time and the management of work within time as palpable features of practice in both settings.
Figure 6.14: Mapping observed practices across MSk and neuro placement settings. (Colours as used in Appendix 1. White space records no observation of a comparable activity)

<table>
<thead>
<tr>
<th>Student activity</th>
<th>neuro WARD</th>
<th>neuro OUTPT</th>
<th>MSk CORE</th>
<th>MSk Hydro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team updates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creating a data base</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning phase with PEd</td>
<td>Pathology, drugs etc.</td>
<td>Pathology, drugs etc.</td>
<td>X-rays</td>
<td></td>
</tr>
<tr>
<td>- Planning the assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-post session MDT activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing clothes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entering interaction sequence</td>
<td>removing furniture / closing curtains</td>
<td>settling the patient</td>
<td>settling the patient</td>
<td>pool entry sequence and hellos</td>
</tr>
<tr>
<td>Seeking consent to treat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debrief with PEd</td>
<td>in space with pt + translation to pt</td>
<td>in space with pt + translation to pt</td>
<td>away from pt</td>
<td></td>
</tr>
<tr>
<td>Objective assessment</td>
<td>PEd led + student practice</td>
<td>PEd led + student practice</td>
<td>student 1:1 with pt</td>
<td>PEd speaks direct to pt</td>
</tr>
<tr>
<td>Debrief with PEd</td>
<td>in space with pt + translation to pt</td>
<td>in space with pt + translation to pt</td>
<td>away from pt</td>
<td></td>
</tr>
<tr>
<td>Pt involvement / discussion</td>
<td>Physio language translated</td>
<td>Physio language translated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise warm up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physio-specific treatment</td>
<td>co-treating</td>
<td>co-treating</td>
<td>1:1</td>
<td>1:1</td>
</tr>
<tr>
<td>Exercise cool down</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home exercise teaching phase</td>
<td>PEd led</td>
<td>PEd led</td>
<td>1:1</td>
<td>1:1</td>
</tr>
<tr>
<td>Social chat (with pts not other PTs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaving sequence</td>
<td>furniture replaced, repositioning pt</td>
<td>Booking appt: Leaving office</td>
<td>Booking appt: Pt leaves</td>
<td>Pt taken away by PTA</td>
</tr>
<tr>
<td>Handwashing / hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing clothes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debrief: Confidence and skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Objective assessment</td>
<td>+ implications for function</td>
<td>+ implications for function</td>
<td>hypothesis generation</td>
<td></td>
</tr>
<tr>
<td>- Goals and plans</td>
<td>PEd led in physio space</td>
<td>PEd led in office</td>
<td>PEd led in dept</td>
<td>student led when note writing</td>
</tr>
<tr>
<td>- How to write notes here</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note writing and signing off</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team updates + bleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In session MDT interruptions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals and pt-specific admin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin and work statistics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Travelling’ to / from workplace</td>
<td>Pushing / carrying equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In sum, although spatial factors appear to be linked to the form of work encountered in that space in generally predictable ways, and the internal structuring of patient-facing interactions followed broad patterns, within these broad structural frameworks lay a complex shifting of interaction participants’ proxemics, kinesics and linguistic practices. As we have discussed in this chapter, the combined effects of the interaction practices in each setting, and irrespective of that setting, placed the patient in the role of data-source object for the receipt of therapist-defined work. While the locally valued discourse of physiotherapy-as-science has been offered as a lens by which the interaction practices of the observed therapists may be explained, the influences of temporal factors (other than the four-week placement timeline) have not been explored in detail in this study. Readers will recall that Edwards and Richardson (2008) suggest that perceptions of time pressures are commonly associated with the (perhaps unnoticed) adoption of therapist interaction practices that privilege hypotheticodeductive reasoning and place the patient in poorly agentic data providing roles. The data in this thesis were collected as snapshots in specific time periods within the students’ placement experiences and can only suggest that some of the observed therapist-controlling interaction practices may capture therapists’ responses to the time management and patient through-put ‘accounting-logic’ requirements (Broadbent and Laughlin 1997) of the local NHS service providers.

This section has drawn together threads of practices and suggested possible interplays between how placement education is practically accomplished and the structural, spatial and temporal features of the context in which that education takes place. Even in the snapshots of placement captured in this study it is clear that students are expected to move between work spaces and to work in expected ways in each setting. Snippets of fieldwork and students’ interview data suggest that the sometimes hour-by-hour transition between workspace, temporal time framing and practice sequence structuring is felt by students as uncertainty and mild practice anxiety until they learn to both spot and reproduce locally valued practices. Exploring the interplay between observable ‘hows’ and contextual ‘whats’ thus offers insights into the ‘mind game’ students feel they are playing on placement. While the structural influences on local practices may be invisible, or not worthy of comment, to staff, the students notice them and, in the setting of a four-week, summatively assessed placement, know that a major part of the early placement game is to spot and recognise affordances and practice expectations. The temporal pressures on students have been evidenced in their explicit concerns to be able to adjust their interaction performances to reflect local expectations early enough in the placement so that they keep to, or even appear to advance ahead of, their PEds’ locally created placement learning timetable.
ii) The physical nature of physiotherapy work

Analysis of both datasets suggests that the physical nature of the work of physiotherapy, its focus on bodywork, influences the learning experiences of placement students in predictable and perhaps more surprising ways. Reviewing the proxemics data has exposed differences in the body work performance of expert and novice therapists with the former more difficult to draw because of their cross-planar (rather than two-dimensional) movement patterns. A further feature of the experts’ practice is their visible ‘intercorporeal knowing’ (Hindmarsh and Pilnick 2007). Intercorporeal knowing is evidenced by therapists’ ability to use their physical contact with the patient in such a way that they appear to respond to both the individual patient’s needs while also complementing the body work of colleagues who may be handling that body simultaneously. Tracking students’ and therapists’ individual body-postures across different forms of physical activity has also suggested that ‘intra-corporeal’ knowing or self-body awareness is essential for effective inter-corporeal practices. Although the physical nature of physiotherapy work frames the students’ learning experiences made visible in this thesis, it is notable that explicit intra-, or inter-corporeal education is absent across placements. Despite witnessing potential physical risks to the patient (or a colleague acting as a practice model) and student or junior therapist of unsupervised, and / or unnoticed novice body work practices, the dominant education focus has been on students’ cognitive rather than physical learning.

In addition to the perhaps expected observable differences in physical work practices between novice and expert therapists, the analyses have also illustrated therapists’ use of proxemics-based interaction practices to both manage the participation of the patient in treatment sessions, and maintain internal team hierarchies. In both placement contexts students and therapists have used physical space (their proximity and alignment to the patient for example) and their direct touch-based contact with patients to direct patients’ body movement. While there may be links between these physical work practices and the therapists’ perception of time and caseload pressures, and / or the perceived need to control patient movements in certain ways to create data appropriate for physiotherapy-as-science accounting practices, the effect of the PEds’ physical work practices in the presence of students consistently places patients in the role of teaching or data collection artefact. Finally, the neuro team appeared to use their team-based physical working in such a way that suggested different staff grades had access to certain body parts and thus treatment interaction roles. In Appendix 3 Figure 1 during a three-therapist interaction for example, an internal team dance led the most junior therapist to the back of the sitting patient, while the student knelt on the floor at the patient’s feet and the senior therapist talked to the patient...
standing by their side. In two-therapist settings the qualified staff member consistently went behind the patient and the student went to their feet.

Collectively the everyday physical practices observed and co-performed by students on placement are influenced by their PEds’ skill expertise and conception of the nature and purpose of physiotherapy work in their context, and the apparent team-wide allocation of body-part / work access.

iii) Educational practices

Each interaction practice observed in this study was of course witnessed by the students I accompanied, and I witnessed the whole as a former physiotherapist and educator. Cognisant of the potential impact of my professional vision (Goodwin 1994) on what I saw and implicitly valued as noteworthy in my field notes, I have, in this analysis, explored long sequences of data in several data forms so that unsubstantiated or snap-shot impressions I may have developed in the field could be challenged effectively. Perhaps as a consequence of this approach, the data analysis in this chapter has exposed patterns of interactional practice across both the MSk and neuro contexts that, while performed in each case slightly differently, appeared to influence individual student placement practices.

Some of the observed interaction practices I attributed to differences in the way the local team structured and organised the placement as a consequence of the team’s work. The MSk team for example worked with generally healthy patients who were allocated to their diaries by the departmental administrator. The combination of pre-allocated patients and a system of daily PEd change created a learning environment where the consistent thread running between the PEds and the collection of patients was, by necessity, developing students’ thinking processes about any, rather than any particular, patient case. The organisational structure of the MSk placement, together with the presence of two students, thus created an environment aligned with the Lead Educator’s vision that the local placement develops students’ ability to think and reason. Similarly the organisation of the neuro placement aligned with Amelia’s intention for students to ‘see it all’ and gain confidence in their neuro practice by ‘having a go’. In all cases the PEds’ practices suggested that their placement goals were orientated to student learning with the patient as a resource for that learning. The PEds’ consistent placing of the patient in the role of resource and the student in the role of ‘the taught’ is notably different from the patient-protection practices of PEds described by Scully and Shepard (1983).
Further, through the discussions and diagrams in this chapter we have noticed PEd practices and looked beyond them to explore the consequent student practices that they enabled. Drawing on Gibson (1977) and Sharrock and Coulter’s (1998) ideas about affordance, we have witnessed student practices that suggest they (or at least some of them) have seen affordances in the structural organisation of the placement and have used these in particular ways to ‘repair’ for what we have identified as a complex situated learning environment (Button and Sharrock 1998; Gherardi 2006).

Throughout this thesis I have described how, from my first contact with PEds in both placement settings, there was no articulation or visible evidence of placement education practices framed about an explicit pedagogy. Instead, by following the structural elements of placement practice, I was able to notice and explore the person-to-person interaction practices by which placement education was accomplished. A central thread in this chapter has been the possible link between the implicit motivations of the people involved in the students’ placement experience and the interaction practices they performed. Drawing on Roth’s (1963) notion of ‘career timetables’ I suggested that each placement learning space is occupied by at least three (four in the MSk context) potentially conflicting timetables or placement practice motivations. While the PEds’ verbal, proxemics and kinesics-based interaction practices with the students and patients appeared to align with their stated placement intentions, the students’ performances suggested that their early placement practices were motivated by their interpretation of the requirements of the summative placement assessment. Assessment-aware practice was evidenced in the data by students’ attempts to use the affordances they spotted in the placements’ organisational structure to effect opportunities (using fellow students, and junior colleagues) to ‘make a showing’ and improve their performance of specific PEd’s expectations of locally ordinary practice (Goffman 1969; Lave and Wenger 1991).

The data in this thesis evidence placement education practices that expose a misalignment between the teaching practices, learning opportunities and assessment proforma and criteria. Despite the stated intentions of the PEd leads in both placement settings, the students’ practices appear to be motivated by assessment performance. The data also suggest that the practices we observed the students performing have been learnt on earlier placements and enable them to both notice the affordances of each placement and respond quickly and effectively. Collectively the performances of the students I observed resonated with Schutz’ (1973) ideas that individuals make choices about how to perform in certain settings and, in an environment where the ‘regulatory rules’ dominate an otherwise invisible
pedagogy (Bernstein 1975, 2000), the students have chosen to perform in ways that manage their PEd’s impression of them positively (Goffman 1972).

6.6 Conclusions

This chapter has used detailed empirical data to expose the threads that weave together, and indeed depend on each other, to create the complex interaction forum and practices to which students are exposed and in which they both agentically and co-agentically practise. Whatever the placement and whoever the PEds and students, the educational experiences observed in this project appear to be framed about the teaching / learning of locally valued accounting practices. Central to the accounting practice, the focus of the therapists’ body work, is their patient. Having completed the data analysis and synthesis I conceive the patients’ place in the education-based interaction in specific but different ways in each context.

I would now describe the neuro patient as the hub in a bicycle wheel about which the wheel of the work of physiotherapy education rotates. As in a bicycle the neuro PEd and students interact with the patient at set points (or spokes) but for their, rather than the patient’s purposes. Similarly, the PEd and neuro student can be conceived as the outer and inner rims of the wheel as they relate to each other in an essentially parallel manner that reflects the different underpinning motivations for their role performances. While the PEd may be using the intersecting briefings to ensure students’ reasoning development for example, the neuro student uses them to assess her performance against the PEd’s implicit practice expectations.

Figure 6.12 described the go-between movement of the MSk students and their PEd and patient. The data analysis extends the description of the MSk students’ movements to suggest a more zigzag interaction that places the patient in the role of an affordance for the student. Conceiving the MSk student patient-facing interactions as a zigzag emphasises how both the PEd and patient effectively pass through the contact time unaware of, but influenced by, the practices of the other. The MSk student manages the patient contact to achieve the outcomes they perceive to be expected by their PEd. In both the neuro and MSk contexts the patients are the subjects of others’ career timetables and interaction practice motivations.

Finally the bicycle wheel analogy resonates with Williams’ description of physiotherapy as a ‘mint with a hole in the middle’, a profession without a clearly articulated core (1986, p. 68).
While the twenty-first century UK profession may still not have a published articulated core of practice, the data in this thesis suggest that its members’ practices reflect biomedical (Lundström 2008) and functional (Sim 1990) perceptions of body and health and teach these to their students through a discourse of science (Lynch and Macbeth 1998). It is not the place of this discussion to question the rationale for these agenda, but issues to do with ‘clean’ body work (Emerson 1970; Twigg 2000), professional competition (Dingwall 1976), and NHS auditing pressures (Broadbent and Laughlin 1997) would warrant further study. Whatever the ‘why’ behind the ‘hows’ of the interaction practices patients experienced in this study, the ‘whats’ effect their agency for their own illness timetable. I conclude the thesis with the following chapter which reflects on the possible implications of this study for the placement education of future UK physiotherapy students.
Chapter 7: Concluding remarks.

This chapter draws the thesis to a close by reflecting on the journey I have travelled in its execution and what I have made visible along the way about the everyday performance of placement based physiotherapy education. The chapter summarises my claim of research originality, demonstrates its relevance for UK physiotherapy education and concludes with some thoughts about directions for further research.

7.1 A journey in noticing and creating noticing-sensitive data collection tools

Chapters 2 and 4 described the change in focus of my thesis that arose as a consequence of my fieldwork access negotiation interviews. Readers will recall that the original intention was to use Bernstein’s ideas (2000) to explore the translation of the pedagogic discourse of physiotherapy placement education from its field of production to its reproduction in practice through a combination of document analysis and ethnographically informed observations in the field (Hammersley and Atkinson 2007). Discussions with placement educators during the access interviews for the fieldwork exposed my misplaced assumption that UK physiotherapy education utilised a consistent pedagogy that was both clearly articulated and consistently applied in practice across placements. The realisation that an explicit pedagogy was not apparent resulted in the project’s refocus to describe the daily practices of physiotherapy education as a foundation for further study. Conceiving the mundane ‘life-as-usual’ activities of physiotherapists as products of the social structures in which they occurred (Gherardi 2006, p. 37), I adopted an ethnomethodologically informed ethnographic approach to observe the consistent practices by which everyday placement-based physiotherapy education is practically accomplished. The focus of the fieldwork thus became the minute physical and multi-sensory elements of physiotherapy placement education interactions.

The need to record multiple components of members’ actions in real time required the development of a new suite of paper and pencil based data collection tools. The tools’ design drew on the work of Birdwhistell (1970), Heath (1986), Goffman (1969) and Laban (Laban and Ullman 1984) and enabled reliable annotation of the proxemics, kinesics and verbal interaction practices observed and co-performed by students on placement. Alone and in combination the data collection tools augmented my word-based field notes to make visible interaction practices that I could not have recorded in real time using words alone (Pollner and Emerson 2001). The development and application of the new method are original features of this research.
The data collection method has been presented to the sociology and health-based academic communities and has been well received. A consistent feature of discussions with colleagues is the extent to which my professional vision influenced both what I saw and noted in the field (Goodwin 1994), and effects the transferability of the data collection tools to others without that ‘vision’. I acknowledge the benefits of my years of training in the noticing of anatomically-described body movements (see for example Everett and Kell 2010), but I have learnt to record movements relevant to social interaction practices from scratch. In the Working Paper to disseminate the method (Kell 2011) I have attempted to make my journey in noticing and refining the tools clear and relevant for others to follow. I have noted too that there are problems with the method when it is used to record the movement-based practices of expert therapists. Expert movements are distinguishable from those of novice practitioners by their three-dimensional, cross-planar performance. I hope to take the development of the tools forward to look at 3D notation on completion of this study. In their current form the tools are useful for others studying movement-based human interactions and also to University-based physiotherapy departments (where the learners’ movements are likely to be two dimensional) to help students notice and think about their personal physical alignment during the performance of therapeutic skills. Students could then use these insights to develop the intercorporeal knowing that this study suggests underpins their profession’s practice (Hindmarsh and Pilnick 2007).

7.2 The status of the data and its analysis

I am aware that the lens or perspective through which I viewed the interactions and undertook their analysis has influenced what I have seen emerging from those practices. Before I summarise the outcomes of my research, it is important to pause and consider the status of the data and its analysis within this thesis. In Chapter 3 I discussed the Special Issue of Discourse Processes in which authors analysed data from the observation of a medical school tutorial. Readers will remember that each author was provided with the same data collected and produced by an unknown other. At the time the works helped me understand what learning as a practical accomplishment might look like in practice and to develop a methodology that suited the needs of my research questions and context (Koschmann 1999). Arriving now at the end of the thesis process, I can see that what I have undertaken is quite different from that of Koschmann’s collaborators. In this study I have collected the data myself, making real-time decisions about what to record and what to omit (Hindmarsh and Pilnick 2007) and I have processed and analysed the data in a thorough, but individual way influenced by my cultural competence in some of the practices of physiotherapy (Pollner 2012).
A core principle influencing each step of my exploration of the fieldwork data has been a concern to avoid ‘imposing an unwarranted order’ on the data ‘drawn from (my) certainties about (the) social structures and other contextual features’ (Horlick-Jones and Prades 2009, p. 416) of the study population. I have thus adopted analytical approaches that have focussed on long sequences of multi-modal field data in order to produce thick descriptions of the data in ways that both act as a ‘nuanced appreciation of the social embeddedness’ of my data (Horlick-Jones and Prades 2009, p. 416) and allow the research participants’ ‘to account artfully for their own actions’ (Gubrium and Holstein 2000, p. 491). The ideas arising from the thesis are thus grounded in context and data rich fieldwork across two distinct therapeutic sites to reduce charges that I have collected only that data I expected to see. While I acknowledge my ‘capacity to incorporate a socially insightful perspective on the action(s)’ I observed (Horlick-Jones and Prades 2009, p. 416), I have offered my perspective of possible explanations for what I think is going on in the data and suggested links between observed practices in each site, but I have consistently and deliberately steered away from adopting a judgemental characterisation of those activities.

Collectively these activities and perspectives have enabled me to lay out a UK physiotherapy version of the everyday work-based learning practices already available for other professional groups (for example Pithouse 1998; Gherardi 2006). Like Pithouse, I have some authority to claim that I know something about what is going on in the field of practices I have observed, but I do not have the currency with modern healthcare contexts to suggest the ‘whys’ for these practices (Gubrium and Holstein 2000). The practices discussed in this thesis work for the groups who practised them and are successful in their achievement of placement-passing students. The next step of the research process must therefore be to ask the profession if they recognise my data and can account for the practices I observed. The final sections of this thesis are thus generated from my assumptions of ‘local knowledge’ but require further reflection and elaboration with the UK physiotherapy profession (Horlick-Jones and Prades 2009, p. 417).

7.3 Placement education: from policy to practice

This project has explored how two hospital-based placements created education experiences that fulfilled the Chartered Society of Physiotherapy’s (2002) requirement that pre-registration students undertake ‘approximately 1000 hours’ of placement learning during which they ‘spend the maximum time possible … in direct contact with patients, enabling them to deploy and refine their physiotherapy knowledge and skills’ (p. 29). By following six third year students in the early weeks of a placement, we have seen how two NHS
placement sites have enacted their requirement within an umbrella framework of intended learning outcomes and assessment requirements provided by the local HEI. In this study the HEI's academic curriculum was aligned with the norms of the local hospital work place structure and created its placement learning around the labels of medically-described pathologies treated by the clinical staff (Roberts 1994). I thus spent time observing the local performance of musculoskeletal and neurology based placement education.

Chapters 4 and 5 used empirical fieldwork data to describe both the organisational structure of local site placement education and elements of the proxemics, kinesics and verbal-based interaction practices by which the education was performed. To some extent in these chapters, but to a greater extent during the cross-site data analysis and synthesis in Chapter 6, I discussed the observed interaction practices as features first of the local group members’ expected practice, and secondly as evidence of a shared cross-placement, more physiotherapy-generic cultural value system (Schutz 1973).

These discussions suggested that, while each placement was organised and managed differently, differences were a consequence of the need for therapists to address efficiently, and in context specific ways, the coexisting demands of case load management and visiting student education. In Chapter 6 we saw that behind the dissimilar structural organisation of the ‘dedicated’ PEd and two-student model of the MSk placement, and the ‘see it all’ neuro model, lay similar placement education practices. Thus in both settings I described the ad hoc nature of students’ exposure to different patient cases with all PEds appearing to ‘improvise practice education from the tasks and materials at hand’ (Atkinson 1992, p. 467). With individual patient case management appearing not to be the focus of the placement education experience, I used the field work data to track long sequences of interactions between the PEd and their student(s) and identified consistent student experiences. As discussed in Chapter 6, each student on both placements engaged in patient contact time that was located within a longer sequence of PEd-led interaction. Following the interaction practices between the PEd, her student(s) and their patient identified the patient as an essential (but non-specific) resource about which the students learned to account for their physiotherapy practice in the way valued by the local PEds (Garfinkel 1968).

‘Accounting’ practices have been a major feature of placement education in both the sites observed for this study. While the MSk and neuro teams valued different practices as ‘accountable’, the process by which accounting was taught was similar with each team facilitating students’ learning through the use of complex, interdependent, multi-form interaction practices. The centrality of social interaction practices as a medium for teaching
resonated with the described practices of situated learning environments (Lave and Wenger 1991; Gherardi 2006).

Looking closely at and following the minutiae of individual's interaction practices, this study illustrates both how learning is an ‘integral and inseparable aspect of social practice’ (Lave and Wenger 1991, p. 31) and offers a physiotherapy-specific perspective of the ‘situatedness’ of that learning. In Chapter 2 I noted that the ideas of situated learning recognised that, while learning may be mediated through social interactions, those interactions themselves are inherently situated in the culture, values and histories of the broader social group of whom the immediately observed participants are a part (Korthagen 2010). Drawing on the empirical fieldwork data we then, in Chapter 6, discussed how co-participation in social interaction practices (verbal, kinesics- and proxemics-based elements) in group-specific ways, did more than confer legitimacy to students in their immediate workspace. While the immediate learning activity was for students to demonstrate locally-relevant performances, the thread running through seemingly disparate interaction participants and practices was the students’ learning to receive confirmation of their developing adoption of the broader common code for working in a profession that valued certain ways of conceiving their therapeutic role and the place of the learner and patient within that role.

The idea that situated learning was the pedagogy of placement education in turn exposed the precariousness of learning for students who variously chose to see, chose not to see, or didn’t notice, the affordances for demonstrating their learning to their PEds (Sharrock and Coulter 1998). The diversity of affordance awareness and associated action choice were traceable through the students’ interaction practices with their fellow student, their patients and their PEds, and made visible an implicit tension within the placement education experiences offered by both placement sites: the mismatch between an invisible placement pedagogy and a very visible (at least in the minds of some of the students) assessment process (Bernstein 1975; Gherardi 2006). In Chapter 6 we heard learners suggesting that, where they sensed a ‘constraining’ learning environment (Gherardi 2006, p. 228) they exercised their learner agency to maintain the practice status quo. The students’ explicit decision-making, similar to that reported in the work-placement education of other professions (Abrandt Dahlgren and Hammer Chiriac 2009; Spilg et al 2012), resonates with Lave and Wenger’s suggestion that, in a learning environment underpinned by social learning practices but using short-term summative assessment, ‘test taking becomes a … parasitic practice, the goal of which is to increase the exchange value of the learning independently of its use value’ (1991, p. 112). In such learning environments the potential of
the ‘naïve’ questions of the novice co-participant or apprentice to effect professional reflection and practice change is lost (Lave and Wenger 1991, p.117).

Following the thread of interaction practices between each of the three main characters in the placement education context (PEd, student(s) and patient) thus suggested that the interaction practices of the students and PEds were motivated by different career timetables (Roth 1963): the PEds by the need to teach, in four weeks, their locally valued knowledge and related accounting practices within the context of other co-existing work frameworks; and the students by assessment driven concerns for the exchange value (in terms of perceived future employment\textsuperscript{13}) of placement grade scores. Neither the PEds’ nor students’ practices appeared cognisant of patients’ perceptions of their health related timetable. Indeed PEds at both placement sites used interaction practices which used patients as ‘the technologies of everyday practice’ (Lave and Wenger 1991, p. 101). In this role patients became individually absent.

Collectively the fieldwork data illustrated that, while most of the students’ daily placement activities could be described as being patient-related, students were in direct contact with patients for about 50% of their time. Unlike their American peers described in Scully and Shepard’s study (1983), the students I observed only interacted with patients for educational or PEd-directed purposes. In the absence of non-education-based observation or explicit discussion about the reasons for the patient-facing interactions students did observe, the PEds in my study might be promoting as typical (and acceptable) the patient absent interaction practices they perform in the presence of their student. PEd: student: patient interactions that place the patient in an ‘absent’ role are reminiscent of the reductionist placement education practices described in the NHS of the early 1990s (Roberts 1994; Stachura 1994), and contrasts with the student-absent physiotherapy: patient interaction practices described by Parry in her more recent conversation analysis-based studies (2004, 2009). Parry suggests that the neuro physiotherapists she recorded were controlling their patient interactions as a device to simultaneously dis-attend to patients’ ‘physical incompetence’ (2004, p. 1002) and account for their own therapeutic intervention. The differences between these groups of findings may be the presence or absence of the student (Strong’s ‘audience effect’ for example; 2001) and the UK therapists’ perception of their role as placement ‘educators’.

\textsuperscript{13} Readers are invited to note that, while immediate attention to the endorsement of their legitimacy to practise may be students’ placement-by-placement concern, collectively the eight placement grades provide deferred access to the work of the profession in some sites i.e. the students’ concerns that ‘less than an A on my CV means I won’t get an interview here’.
7.4 Implications of this study for the placement education of physiotherapy students

This study provides a detailed map of some aspects of everyday practices in physiotherapy placement learning environments. While this study is unique in the depth of data it has collected of real time placement education, my outcomes resonate with those of other studies that have used patient histories (Johnson 1993), videos of stand-alone PEd: student: patient contact sessions (Laitinen-Väänänen et al. 2007) or student interviews and reflective journals (Geddes et al. 2004; Lindquist et al. 2006; Skøien et al. 2009) as data collection methods. Consistently these studies have challenged the physiotherapy professions of their respective countries to notice the mismatch between professional rhetoric that promotes patient-centred models of care in accordance with the requirements of the WHO (McIntyre and Tempest 2007), and the reality of student-present therapist-controlled interactions. My study corroborates some of these earlier findings and could be used by the profession to support a ‘revolution’ in its underpinning ontological and epistemological perspectives (Kuhn 1996)\(^{14}\). But before I get ahead of myself, it is useful to explore the scale of challenge facing practice change. Figure 7.1 provides a schematic representation of the typical pre-registration programme timeline of a physiotherapy student at the study HEI. This visualisation raises two issues about practice change which I explore briefly before drawing the thesis to a close.

Firstly, Figure 7.1 places my data, collected from the observation of a small segment of one of the students’ eight work-based placements, in the context of their whole pre-registration learning experiences. The third year students in my study had each completed a year in university-based education environments where their educators, although academics, are registered UK physiotherapists, and at least four previous placements in a variety of NHS hospital- and community-based work-placements. Figure 7.1 thus locates the students in the webs of situated learning experiences that surround all those who interact with them (Gherardi 2006). This web of shared experiences resonates powerfully with Lave and Wenger’s notion of ‘decentred mastery’ in communities of practice (Lave and Wenger 1991, p. 94).

\(^{14}\) Readers will recall from Chapter 2 that I suggested that UK Physiotherapy may be on the cusp of a ‘revolution’ of its world view with increasingly frequent challenges to its patient practices appearing in the profession’s magazine (see for example: Letters 20/06/12 where, in a response to a paper in the BMJ warning physios to stop cervical spine manipulations, Roger Kerry (Physiotherapy Lecturer University of Nottingham) writes ‘That the BMJ article was written by physiotherapists is a particularly depressing signal that we are moving closer towards the realms of pseudo-science, with gross ignorance of the complexity and context-sensitivity of healthcare.’ [http://www.csp.org.uk/frontline/article/letters-20-june-2012](http://www.csp.org.uk/frontline/article/letters-20-june-2012). The depth and breadth of my fieldwork data could provide a resource to support a cross-profession practice critique.
Lave and Wenger suggest that, in a situated learning environment framed about participants’ progression through repeated ‘development cycles’ and ‘centripetal participation’ (1991, p. 100), mastery resides not in the master but in the organisation of the community of practice of which the master is part. Gherardi et al (1998) extended these ideas following their study of the fieldwork-based learning of construction industry apprentices, and adopted the term ‘situated curriculum’ to make visible the link between the social structure of a group’s practice and ‘the way these structures define the possibilities for learning’ (p. 279).

Conceiving physiotherapy placement education from a situated curriculum perspective may be helpful for the future development of the profession. Consistently in this study we have observed students taking part (like Lave and Wenger’s quartermaster apprentices) in the whole workflow of a patient case. In Chapter 6 we saw how, in the physiotherapy placement context, a patient-case workflow involves linear sequences of dyadic and occasionally triadic interactions. Throughout each patient case the step-wise, PEd-controlled curriculum could be an attempt to guarantee that the students can perform all elements of their case’s tasks, within a framework that prevents errors which might ‘jeopardize the safety of everyone’ (Gherardi et al 1998, p. 288).

The consistency of the students’ performance of PEd- and patient-facing proxemics, kinesics and verbally based interaction practices observed in this study has been a repeated theme throughout the thesis. While specific practices across placements may vary to some
degree, there is an underlying consistency to interaction practices that the students I observed had already mastered, and which, when re-presented in the context of their new placement, were expected and thus unnoticed. While assessment alertness may act as a ‘cultural relay’ for the students’ adoption of anticipated practices (Bernstein 1990), the students’ practices possibly evidence a community-wide situated curriculum that has at its heart a concern for the safety of its patients.

The second issue arising from Figure 7.1 is thus the value of the student voice in explaining the rationale behind interaction practices I observed in the field. The students in this study had successfully navigated two-thirds of their degree programme, so recommendations for practice development arising from them in this thesis must be mindful that they are products of the system and thus potentially blind to features of their own practice. The students have been an invaluable resource in this project and alerted me to the affordance potential of placements, but I must remain true to the real time data I have collected and recognise that the consistency of placement practices I observed is as likely to be the product of repeated cycles of centripetal participation within an embedded situated learning environment, as influenced by summative assessment processes. The data suggest that there is more underpinning the absence of student agency than assessment practices alone, and that any quick fix recommendations from this study (for example the decoupling of assessment practices from placement learning) would be superficial. Indeed, Gherardi et al warn that adjustment to a situated curriculum ‘from its own original practical context where is makes sense and works’ (in this case produces successful graduate physiotherapists) ‘can produce unintended and undesirable effects’ (1998, p. 294-5).

Collectively my data evidence students learning in a complex situated learning based context with unique characteristics that remain poorly understood and whose very professional organisation challenges the profession’s ability to respond to calls for practice change (Button and Sharrock 1998; Edwards and Richardson 2008) and instead perpetuates cross-generational perspectives of specialist contrived patient-absent healthcare (Laitinen-Väänänen et al. 2007).

7.5 Reflections on this project and recommendations for further study

This project makes a significant contribution to the study of physiotherapy practice and its practice-based education. The new data collection tools can be used across the profession both to teach students and therapists safe bodywork techniques, and to collect data to enable physiotherapists in other universities, hospital- and non-hospital settings to explore
local interaction practices. The rich datasets in this thesis offer the UK profession a first step in noticing some of the features of the student-present patient, and colleague interaction practices by which the CSP’s national curriculum guidelines for work-placement education are achieved (CSP 2002).

A challenge for researchers seeking to build on this work is the complexity of the situated learning environment of physiotherapy. While further studies to explore the placement practices and agentic motivations and choices of specific groups of students (for example those on their first placement, the ‘second’ student in 2:1 placements, those who choose not to comply with community expectations with respect to patient care, those from universities whose placement assessments are not summatively assessed etc.) have been suggested throughout the thesis, the relevance of such studies is challenged when the methods by which the profession’s community of practice is both created and sustained remain unexplored. There is thus a need to focus future research on the ‘intricate structuring of the community’s learning resources’ (Lave and Wenger 1991, p. 94).

Two specific projects could stand alone from, but inform, this work to unpack the ‘essence’ or the ‘hole in the middle’ of the profession (Williams 1986). The first is to build on Johnson’s study (1993) and explore the patients’ side view of physiotherapy interactions in multiple settings, in interactions where students are present and absent, and with many different therapists across career grades. While in part an essential step to examine my claims in this thesis that patients are controlled by and effectively absented from discussions about their own physiotherapy care, such a project could also begin to explore the notion of expertise in physiotherapy practice.

Throughout this study I have evidenced placement practices that promote local accounting development and knowledge acquisition and rendered almost invisible (certainly in the MSk context) therapist expertise in the actual performance of the body work of their trade. The proxemics-based data have exposed tangible differences in the way that novices and experts perform their bodywork, but also a consistent absence of any talk about it. A detailed exploration of skill-based expertise is an essential next step project. The outcomes of such a study could not only make visible the mastery that resides in the individuals of the profession (rather than in the community of practitioners), but also enable physiotherapy to celebrate intercorporeal knowing as the core of its practice. A celebratory claim to professional bodywork expertise could reduce the emphasis on accounting practice as a form of professional identity and unify the profession around a common core which rejects Sim’s suggestion that UK physiotherapy is nothing more than ‘an amalgam of somewhat sporadic
and unrelated professional activities’ (1990, p. 423). I look forward to contributing to these discussions.
References


Qualitative research for allied health professionals: challenging choices. Chichester: John 
Wiley & Sons, Ltd, pp. 79-91.


Research International 7(3), pp. 170-186.

Rose, M. 1999. 'Our hands will know': the development of tactile diagnostic skill - teaching, 
learning and situated cognition in a physical therapy programme. Anthropology and 

Roth, J. 1963. Timetables: structuring the passage of time in hospital treatment and other 

social action: studies in conversation. Cambridge: Cambridge University Press, pp. 413-
429.

Ethnomethodology: selected readings. Middlesex, England: Penguin Education, pp. 233-
264.

Martinus Nijhoff.


147-164.


of doctors in the UK National Health Service. Social Science and Medicine 75, pp. 1617-
1624.

357-360.

Strong, P. 2006a. Minor Courtesies and macro structures. In: Murcott, A. ed. Sociology and 
medicine: selected essays by P. M. Strong. Aldershot: Ashgate Publishing Limited, pp. 37-
56.


Appendix 1: Full text of ward-based neuro placement interaction sequence.

A full running sequence of field note data illustrating text and sequence analyses

Having spent the morning doing new patient assessments with the outpt team, Verity joins the ward team for the afternoon. We join her as she and Amelia her mentor arrive on the ward. The plan is for Verity to accompany Amelia for a ward-based new patient assessment.

Day 1 1.40 p.m.
Cluster of nurses about central nursing station, place also buzzing with medics;
Amelia near desk and discusses a new pt/, update from hand over she had with nurse earlier. Both looking at notes’ file. Asks Verity if she is happy to do a data base for the new pt;
Hunting for notes, Amelia asks Verity to ask the Drs;
Amelia leaves: “Will do stairs with Lorna (Band R) and be back”
Verity to nearest male medic: “Have you got the notes for X?”
Dr hands over, no comment;
Verity: “Thanks”; To CK: “That was easy.”
Dr to Verity: “Can I just have a sticker out of the back?”
Verity finds one and gives it to him.

1.45 pm
Verity starts making notes standing by notes’ trolley;
Verity to CK: “Good job I have done this before. I hope they do this like on my other placements.”
Verity perching notes and physio card on edge of desk. Every inch of space being used by 3 medics (2 with stethoscopes around neck) and ward administrator on phone;

1.47 pm
Amelia returns and happy to see that notes are available;
Amelia takes notes, moves to lean on notes’ trolley and orientates Verity to notes and looks at pt physio card and helps Verity complete front page sections (Sketch below);

Advises Verity where to find rest of info needed
Amelia leaves Verity writing notes ‘to see another pt’

1.51 pm
Overheard by young, white-coated, male doctor (?) Most junior. Having translation problems?

Verity shows the page. Or takes page, recognises the writing – not his. Tries to help but struggles himself – laughs (quick flash of eyes to male medic behind desk – ignoring us) and walks away.

1.56 pm

Lorna and Amelia walk past with pt, smile to me, Verity doesn’t notice as has her back to them;

Verity still making notes on card;

1.58 pm

Nurse approaches trolley. Reaches by Verity’s left knee. Verity hasn’t seen her approach, jumps: ‘Oh sorry.’ Moves Nurse takes notes, smiles to floor, walks away;

Amelia and Lorna walk back, Verity still unaware;

(CK note to self: think I am already invisible, I am so glad I’m wearing blue and trousers. Only female doctor is wearing a skirt here)

2.00pm

Four doctors looking at screen behind us and talking about an image on the screen. The only male doctor without a stethoscope is clicking the mouse. When he stands up the others do too and look at him ?? he is the senior?

Amelia returns, Verity shows her the words she couldn’t read. Amelia has a go. Explains some new terms, plenty of eye contact with Verity.

Amelia: ‘Shall I show you where the cardexes are? You can sometimes get information from that.’

Speaks to nurse to ask whereabouts of cardex. ‘Not here.’ Only responses, nurse gone.

Amelia waves hand (?) in exasperation: ‘Around here somewhere is a blue folder…’

2.05 pm

Amelia and Verity standing very close together at [nursing station]

Verity reporting back on her database. Queries names of drugs. Amelia shows where to find BNF. Corrects names of drugs.

Amelia tells Verity how to [single-line cross-out and initial correction on notes]

Amelia: ‘Do you know much about X (pt’s condition)?’ Focuses eye contact on Verity while Verity answers. Amelia completely still;

Verity looks down corridor and closes eyes briefly as thinking answer before speaks;

Chat together about pathology, both onset running hands down own arms as asking.

Amelia left hand on notes. Talking about IgG. Moving on through pathology talking about reason for pt’s admission.

Amelia: ‘What would you do about assessment?’ Turns to face Verity.

Phone ringing. Amelia and Verity ignore. Lorna passes by, picks it up, NA comes to investigate, Lorna passes her the phone.

Verity replying to Amelia. Amelia nodding. Then still, waiting as Verity continues.

Amelia: ‘Are you happy to do the assessment?’

Verity clarifies: ‘It’s a lot about muscle strength’?

Amelia: ‘So would you like me to do and then you?’

Verity: ‘Well I would like to see one so I know...’

2.15 pm
83 Approaching the patient (82 year old female)
84 Amelia first. As approach Amelia jakes and moves pt's table but of the way.
85 Verity goes for the curtains and starts to close. Pt is asleep in the chair.
86 Verity comes to one side and sits on the bed.
87 Gently wakes pt. and asks if they can do your physio?
88 Pt wakes and asks Amelia what she is doing.
89 Amelia explains about how they are going to ask her some questions and then see how she is getting on.
90 Verity starts questioning: “So how are you getting about?”
91 Pt: “a bit wobbly”
92 Verity: “So is it a balance thing?”
93 Pt: ‘No I’ve lost my confidence.’
94 ? Verity struggling to find questions to get pt. to talk: ‘We will take few measurements if that is OK?’
95 2.20 pm 2-person stand to remove pillow from her chair as pt is slipping forward.
96 Amelia approaches pt. (sketch below). Verity stands back in ‘anxious’ pose, playing with shirt button;
97 Amelia: “You mentioned that your legs are weak...”
98 Pt: “Yes, but what I’ve noticed is that my writing has gone off.”
99 Amelia [starting to touch pt].
100 Explains to pt. that she will be explaining [hugs to Verity]
101 Amelia to Verity: ‘I’m just going to do a global assessment.’ (Pt focuses intently on Amelia’s face) ‘So we will try with some chair-based leg exercises.’
102 Amelia explains what she is going to ask her to do. ‘So can you... that’s good... fine.’
103 Amelia sharing with Verity what she has found, both looking at pt and then at each other.
104 2.25 pm
Amelia sorting books and papers off bed and put on table.

Pt stands with help from Amelia and Verity and turns to bed. Settle lying on the bed.

Verity: ‘Loss of coordination?’

Amelia explains to the patient what talking about: ‘I’m just going to talk to Verity…’

Stand by each other, eye contact ++, Verity offering, Amelia nodding;

Amelia: ‘So what are you now going to assess?’

Quiet response from Verity;

Amelia: ‘It might be good if I do them first and then you have a practice – to feel later.’

Amelia starts doing assisted and resisted leg exs to right leg. Eyes focused on pt. Gives pt. quiet instructions. After each movement turns to Verity to say what she has felt;

Amelia to pt.: ‘Can Verity have a go as well so she can feel’;

Verity seems deep in thought, and focussing on legs++, minimal eye contact. Visibly thinking through sequence she has just seen Amelia do.

Verity to Amelia: ‘I think I have forgotten one,’ Amelia answers;

Verity: ‘How would you do that?’

Amelia verbally explains, Verity tries, clumsy handling, Amelia corrects.

2.33 pm Verity doing same with left leg.

Amelia: ‘You could do the active exercises first?’

Both huddled over bed, looking at leg.

Curtain flies open Ward Manager (female) and Male in a suit enter.

Maes says ‘Hello.’

Few quick questions to pt.: ‘What have you done? Have you had any tests done today?’

Ward Manager answering all ques before pt. Pt lying on bed, smiling at male.

Male: ‘OK see you again.’ Leaves.

Ward Manager closes curtain behind her.

2.35 pm Amelia: ‘Short and sweet.’

Pt: ‘He came to see me in X hospital – lucky I am!’

Amelia queries.

Pt: ‘Oh yes, only special visitors I got.’

2.36 pm Amelia talking Verity through sensation testing.

Amelia on pt’s left side doing left leg, Verity then copies on right.

Amelia to Verity: ‘So now we are going to do… What would you do?’

Verity explains;

Amelia: ‘OK X, I’m just going to do…’ does.

Amelia qualifies to make exercise more challenging.

Amelia explains how to test proprioception (even though I saw Verity do this this morning in a new pt. assessment in outpt), Amelia does;

Verity watching pt’s toes and face as Amelia does test. Unclear pt response;

Amelia questioning more carefully - ? not assuming pt’s response is ‘correct’. Test at ankle: ‘Seems to be OK.’

Verity starts repeat on right leg.

Amelia amends her technique, Verity repeats closely watching pt’s face.

Amelia: ‘Was that a guess?’ to Verity: ‘Repeat at the ankle like I did.’

2.45 pm

NA pops head around curtain: ‘Are you seeing Y?’

Amelia: ‘Yes’

NA: ‘I will put a pad on her.’

Amelia start to move towards her. NA says: ‘I have taken her catheter out, so…’ smiles to Amelia.
Amelia: "OK..."

NA leaves.

Bed assessment complete. Amelia talking to pt. (sketch below, Verity standing at bed end watching)

Amelia: ‘Before we tire you out, we would like to take you for a walk;’
Pt: ‘If I must. So long as you [don’t make a fool of me].’
Amelia smiles: ‘No, I will go and get a frame.’
Verity has a conversation about pt’s slippers.

2.50pm Amelia back. Bed manoeuvres to get bed moved so room for supported standing and frame, help pt to sit and then stand.
Amelia taking lead. Arm firmly around pt. (Sketch below, Amelia on left). Talking to Verity behind pt’s back re exercise tolerance.
Amelia to pt.: ‘Let’s try some marching up and down.’
Verity asks pt to ‘Take your feet further apart again.’ Both watching pt’s face;
Amelia asks pt. to sit. Talks to pt. about different forms of walking frame;
Amelia to Verity: ‘I’m thinking about the Steddy.’ She leaves to fetch it.

2.55 pm Verity chatting to pt. ‘Must have been a big shock. ... A bit of a mystery. Pt sitting
on bed. Verity in her chair;
Pt tells her about how she goes to bingo, sequence dancing and other clubs. Verity leaning
forward, eye contact ++

Amelia back with Steddy;
Pt: ‘How can I walk with this?’
Amelia: ‘We don’t necessarily need you to walk. You can do this (shuffle with two people)
now and do walking in therapy.’
Use Steddy to transfer to chair.

3pm Band 5 pops head in looking for Lorna;
Amelia: ‘I will be out in a mo.’

Amelia: ‘Verity and I will go away.’
Pt: ‘I am in your hands now.’
Amelia: ‘I’ll leave you with Verity.’
Pt: ‘Yes thank you, you get along now.’
Verity and CK clear up bed are and put everything back, open curtain;
Say goodbye to pt;
Amelia: ‘We will come and see you tomorrow.’

Verity carries frame way
Communal hand washing

Amelia feedback to ward manager about what just done. quick thoughts on plans. Comes to
join us in sluice to wash hands;
Amelia to Verity: ‘I would have let you do it, but X was just passing’

3.06 pm In physio space behind nurses’ station.
Amelia: ‘What did you think?’
Verity offers
Amelia and Verity discuss ‘Slightly odd presentation’.
Amelia moving her hands ++ and stamping her foot when talking about pt. in standing;
221  Asks Verity why she thinks pt was stamping her foot. Offers 'co-contraction?'
222  Amelia: 'Thinking more of a neuro emphasis? To increase stimulus, so she can hear her
223  foot.'
224  Discuss future plans.
225  Amelia: 'OK so can you write that up? Do you want a crib sheet to follow the headings?
226  Goes to fetch, to CK: 'Verity has not been on the ward much so still finding her way.' (Verity
227  has been with Amelia while Amelia did a day's teaching on splinting and casts for one day
228  and then one day about emergency on call. With Day 1 as a Trust induction day, this would
229  be the first full session on the ward.)
230  3.10 pm
231  Amelia: 'This is the form most people prefer to use the first time.' Explains how it works to
232  Verity.
233  Verity writes something in nursing notes;
234  Leaves Verity to write up assessment.
235  Amelia going downstairs to pick up an exercise mat for someone else. Smiles. Leaves.
236  3.15 pm
237  Verity needing drug information, CK and Verity hunt and find at bed end.
238  Back in 'corner' Verity writing.
239  3.20 pm
240  Amelia back with mat. Writing pt's medical notes. Offer quick 'ankle lump' consultation to an
241  NA.
242  3.25 pm
243  Verity asks Amelia about the form completion;
244  Amelia finished notes, returns to main desk, comes back;
245  Amelia: 'While you are doing that I will just go and ...' leaves;
246  Verity asks CK a question, but answers it herself;
247  3.34 pm
248  Verity still writing;
249  Nurse: 'None of you have Z's folder?'
250  Verity looks up, smiles: 'No sorry.'
251  3.38 pm
252  NA approaches Verity asking how long before we see next pt;
253  Verity: 'As soon as Amelia has finished.'
254  NA: 'How long it that likely to be?'
255  Verity: 'Um, shall I go and ask Amelia? Leave
256  Verity back: 'Very soon, Amelia is just finishing off.'
257  3.40 pm Amelia is back. Talks to NA: 'We are going now.'
258  Verity: 'Shall I leave this then, I'm just finishing?'
259  Amelia: 'No, carry on.'
260  NA discussing (with nurse) how needs to change mattress: 'Everything is ready, we are just
261  waiting for the physio to see her.' Ignored by Amelia and Verity.
262  3.44 pm
263  Discussing notes. Amelia clarifies need to state time started session.
264  Amelia clarifies re what Verity meant by gait assessment and balance control assessment'
265  Verity amends and initials changes.
266  Amelia: 'Right, we will do the rest later! The next pt we are going to see is F...'
Appendix 2: Getting into the neuro placement mind-set: preparing for a close exploration of students’ learning experiences.

Figure 1 presents two typical field note extracts that illustrate the blur of neuro practices I experienced on my first day in the field. In this Appendix I process this data to make sense of the seemingly disparate practices and lay the foundation for the neuro student learning experience discussion in Chapter 4 of the main thesis text. The data in Figure 1 is taken from my first day in the field with Verity. The first extract preceded a morning spent in the neuro outpatient treatment room (with Lucy the Band 6 therapist as the named PED), while the second captures my first experience in the ward setting (where the Team Lead Amelia was Verity’s named PED). Despite this being her fourth day on placement, Figure 1 also records Verity’s first experience of the ward.

Figure 1: First experiences with the neuro team.

Extract 1: Morning treatment room interaction

1 Arrive 8.20 am
2 Knock on Neuro room door: ‘Come in’.
3 Walk in to find 3 female physios in the room: one I know (Lucy, female, pony tail, blonde, young, aertex) says ‘Hello Clare how are you?’ and then turns back on me to continue reading something on her desk (my consent form);
4 Other physios unknown, one sitting on plinth the other chatting to her while leaning on a wall.
5 …
6 8.26 am
7 Amelia, Verity + 1 other female physio arrive, smiles all around;
8 Verity seems a bit at a loss, sits on near corner of plinth;
9 Amelia, standing by desk, tells me she has done 2 consents for me already - including one blind lady:
10 ‘I sat down and talked the lady through everything, and got verbal consent for each item. I did it to save us time today, and the Ward Managers are expecting you so we will play the other consents by ear.’
11 Amelia goes to drawer to take out the consent forms that she has done for me. My bag is in the way, I get up to move it... and I see a file at the front of the drawer called ‘Clare Kell’s Research Project’. All my letters and copied consents seem to be in there.
12 8.30 am
13 Now 5 physios, 1 student and me in this space. Lucy on her own still reading at desk;
14 Amelia sits on plinth with a large blue diary on her lap, between one physio and Verity. These three sit in a row facing me (sat on a stool), another physio standing leaning on wall and one sits next to me on chair;
15 Of the 5 physios here, 4 wear tunics, 2 with stethoscopes peeking out of pockets. The student and Lucy wear aertex tops.
16 Amelia opens diary on lap: ‘OK then’, uses hands to spread over diary, ‘Please can I introduce you to Clare who is here for a few days with Verity, watching Verity. She will be with Lucy this morning and me this afternoon.’
17 Everyone turns to me and smiles – I have no idea who they are. Lucy, sitting on her own at the desk reads and ignores us.
18 Amelia proceeds to talk to each person in short, clipped but soft phrases:
19 ‘Checking you have induction at 9?’

15 The neuro room is a small, windowless space accessed from the main outpatient waiting area. It is notionally divided into two distinct areas by two tall filing cabinets and a portable wheeled screen. At the end nearest the door two desks line the walls, one with one chair and a computer, the other with two chairs and the telephone/answerphone. All walls at this end of the room are covered with flyers, charts, memos etc. The therapy area in the room is uncluttered, housing a large therapeutic plinth against one wall with enough space for two upright chairs, a stool, a small arm table and a cream-coloured lockable cupboard. A widely available picture of a spine with nerves annotated is stuck on the wall above the plinth. A door at the end of the plinth leads, up a small ramp, to the generic gymnasium where more plinths, exercise bikes and space for class-based activities are found. When a patient is called into the neuro room the therapist sticks a ‘Session in progress: Please do not enter’ laminated sign on the outside of the door. Neuro team staff still enter to access the desks / perform their admin tasks but pull the screen to close off the patient area.
‘You have an appointment at 9 so you and I can talk about things this afternoon’
To group: ‘I have tried to save a couple of patients for Verity and Clare to see, so I will need to catch
up with you about that. OK, I think that is all that is happening today.’ Closes diary, people get up and
leave room.

8.35 am
Lucy turns to Verity who has twisted on plinth to face her around screen: ‘OK so we have 2 news.
Shall we go through them?’

Sense Verity is prepared for this as pulls notebook from trouser pocket and opens it.
Lucy asks Verity if she has any ‘ideas about how they do a diagnosis?’

Verity long pause, short response, expanded by Lucy;

Verity: ‘Oh yes I think I read about that.’

Questioning continues as, to the side of us, Amelia, the only other person now in the room, sorts
papers. Amelia moves to and opens filing cabinet between Lucy and Verity, not acknowledged.

…. (Questioning and private reading continues until patient arrives at 9.25 am)

Extract 2: Afternoon ward interactions 1.30 p.m.

Back in outpatient room after lunch waiting for Verity to come back from toilet;

CK sitting, ignored except occasional smiles if eyes caught;

Amelia, standing, talking to colleagues and directing their first activities this afternoon: ‘So if you come
with me and then you can…’

Verity arrives we leave for ward. Fast walking down corridors, Verity and I behind others, silent in lift
which we almost fill with a couple of patients too. Leave lift together, split off to wards. Amelia, Verity,
one other physio and I enter ward;

Other physio walks down ward to right, we approach main desk;

Cluster of nurses about central desk, place also buzzing with medics behind to one side and in front to
one side of main desk and clustered around computer screens behind us. Only a Ward Administrator
(on the telephone) is behind the central part of the notes-strewn desk. She stands but her chair is
positioned to look at the centre of the entry corridor and automatic doors;

Amelia nears desk and talks to Verity about a new pt she has picked up from the handover she had
with a nurse earlier.

Verity and Amelia looking at medical notes file;

Amelia: ‘Are you happy to do a database for the new pt?’ Gives Verity a blank physio card;

Hunting for medical notes, Amelia asks Verity to ask the Drs.
Amelia leaves: ‘Will do stairs with Lorna (Band 6) and be back’

Verity to nearest male medic: ‘Have you got the notes for X?’

Dr hands over, no comment;

Verity: ‘Thanks’. To CK: ‘That was easy.’

Dr to Verity: ‘Can I just have a sticker out of the back?’

Verity finds one and gives it to him.

1.45 pm

Verity starts making notes on physio card standing by notes’ trolley;

Verity to CK: ‘Good job I have done this before. I hope they do this like on my other placements.’

Verity perching notes and physio card on edge of desk. Every inch of space being used by 3 medics (2
with stethoscopes around neck) and ward administrator on phone.

1.47 pm

Amelia returns and happy to see that notes are available;

Amelia takes notes, moves to lean on notes’ trolley and orientates Verity to notes and looks at pt
physio card and helps Verity complete front page sections (see sketch, Amelia on the left);
Advises Verity where to find rest of info needed.

Amelia leaves Verity writing notes ‘to see another pt.’

1.51 pm

Verity writing notes. Struggling with reading writing. Unclips page from notes. Comments to CK.

Overheard by young, white-coated, male doctor (? Most junior). ‘Having translation problems?’

Comes around desk to have a look, smiles;

Verity shows the page. Dr takes page, recognises the writing – not his. Tries to help but struggles himself – laughs (quick flash of eyes to male medic behind desk – ignoring us) and walks away.

1.56 pm

Lorna and Amelia walk past with pt, smile to me, Verity doesn’t notice as has her back to them;

Verity still making notes on card.

1.58 pm


Nurse takes notes, smiles to floor, walks away;

Amelia and Lorna walk back, Verity still unaware;

(CK note to self: think I am already invisible, I am so glad I’m wearing blue and trousers. Only the female doctor is wearing a skirt here).

2.02 pm

Amelia returns, Verity shows her the words she couldn’t read. Amelia has a go. Explains some new terms, plenty of eye contact with Verity.

Amelia: ‘Shall I show you where the cardexes are? You can sometimes get information from that.’

Both move off down ward to right. Amelia stops at bed board, explains initials, ward layout, consultants;

Arrive at smaller nursing station. Amelia asks nurse the whereabouts of cardex. ‘Not here.’ Only response, nurse gone.

Amelia waves hand ? in exasperation: ‘Around here somewhere is a blue folder…’

2.05 pm

Amelia and Verity standing very close together at nursing station. Notes resting on another pile of physio cards and diary ? this is a physio space?

Verity reporting back on her database. Queries names of drugs. Amelia shows where to find BNF.

Corrects names of drugs.

Amelia tells Verity how to single-line cross-out and initial correction on notes;

Amelia: ‘Do you know much about X (patient’s condition)?’

Focuses eye contact on Verity while Verity answers. Amelia completely still;
Verity looks down corridor and closes eyes briefly as thinking answer before speaks;
Chat together about pathology and onset, both run hands down own arms as talking about proximal to
distal onset pattern.
Amelia keeping left hand on notes. Talking about IgG. Moving on through pathology talking about
reason for pt’s admission
… (question and answer discussion continues until move to see patient at 2.15pm)

Figure 1 captures approximately 40 minutes of Verity’s fourth day with the neuro team. The
details of the extracts will be explored in more detail in the next section, but at first reading it
is possible to sense the bustle of the placement and the number of people (both
physiotherapists and other health workers) with whom the student had to interact, even
before she met a patient. The speed and diversity of locations, sounds and smells of my first
period of observation with the neuro team was disorientating and my disorientation was
compounded every time I came back to the field with different students having different PEds
and seemingly different placement experiences.

Making sense of a neuro placement

I use Figure 1 to illustrate how a deepened sense of noticing enabled me to see streams of
seemingly unrelated activities as comprising internal consistencies that foregrounded the
work and values of the team I was observing.

a) Physical spaces, artefacts and roles

The field notes in Figure 1 suggest that physical space, both in the outpatient and ward
settings, play a part in demarcating work practices. In Lines 2-20 for example, the therapists
have positioned themselves at different ends of the neuro room which itself is furnished for
different functions. Lucy, though in the minority, separates herself from the work of her
colleagues with activities only she performs in the space that only she occupies. While, in
Lines 15-17 and 45-46, Amelia (the Team Lead) seems to be able to access all areas of the
space in this room, the more junior staff loiter while waiting for briefing meetings and leave
immediately briefings are completed. Lucy’s implicit ownership of the room is perhaps
suggested in Line 2 by her calling me into the room at my knock, while her status within the
team (rather than her being rude) may be signalled by her returning to her reading rather
than introducing me to her ward colleagues in Line 4.

Figure 1 also illustrates my first attempts at recording the clothes and visible artefacts used
by the individual therapists. With participants wearing identical blue nylon trousers, blue /
black lace-up shoes and having their hair up and clipped back from their faces, the group
foreshadow their work as requiring a freedom of movement and movement stability without
the distractions of dangling hair. However not all therapists were wearing the same upper
body clothing. It is noticeable in Lines 24-25 that the ward-based therapists wear tunics that
are long, go over their trousers and have pockets which are clearly full of things, though only
two stethoscopes are visible. Lucy and Verity wear white aertex tops tuck ed into their
trousers. While Verity’s attire is a requirement of her ‘student’ uniform, Lucy’s lack of need
for pockets perhaps suggests that she has no need to carry her world around with her as
she has a space that is hers here. The presence of bulging pockets and stethoscopes for the
ward staff foreground a nomadic work environment where expensive, difficult to locate
equipment (e.g. a stethoscope) is best purchased and carried on your person.

Indeed Lines 50-128 in Figure 1 support the idea that physiotherapists on wards must
compete for space with other health workers and that the way this is accomplished on the
ward observed is by professions having different notional spaces. Within this spatial setup
tensions appear when professional groups need to enter and work briefly in each other’s
spaces. Lines 58-72, 99-101 and 112-114 offer three examples of what I think are tolerated but not encouraged invasions of professional spaces. In each case the intruders are accommodated so that they can do the elements of their work that require co-space working, but they are not enabled to do this in comfort or with ease!

Space ownership and space use is a recurring theme in this thesis and has challenged my previous assumptions about cross-team / cross-professional working. The ward-based elements of Figure 1 illustrate how the written word (the medical notes, the nursing cardex, the wall-based bed chart and the physiotherapy card) dominate the away-from-patient work of the professions. Each form of document appears to record different features of the patient’s case with the physiotherapists needing to access both the nursing and medical documentation to create their own ‘database’ of the patient. And, as Lines 75, 84 and 121 suggest, while there is a standard format to the creation of a physiotherapy database, Verity must learn the specific requirements of the ways they are completed and corrected within her current team.

Perhaps most striking from the interaction sequences captured in Figure 1 is the way Verity blends into the spaces in which she finds herself. While I was all at sea and struck by the emphasis on the written word rather than verbal communication between the healthcare teams, Verity appeared outwardly calm, able to achieve the outcomes she needed and blind (or perhaps innocent) to the interprofessional hierarchy games I felt were being played out around her.

b) Temporal spaces foregrounding the focus of work

After cycles of data processing I see explicit signals in Figure 1 about the opportunities and challenges placed on the work of neuro physiotherapists (and thus the placement education of their students) by the way their work was organised. In the outpatient setting (Figure 1 Lines 39-47) Lucy and Verity sit down, in their own physical space, to discuss a new patient assessment. Because the outpatient team operate a diary patient booking system, Lucy knows that she has almost an hour before the first patient arrives. While Lucy does not use all this time for Verity, there is a definite sense of calm and focus on task in this space. In contrast on the ward, Amelia regularly disappears using her time away from Verity to interact with patients. Thus from even our first minutes on the ward, it should have been clear to me that Verity and I were in a space where the work of the physiotherapy team was patient case load focussed. Knowing the team and their work as I now do, I can see how the interactions in Figure 1 foreground Amelia’s expertise as a team leader. Through her twice daily ward-team briefings (Lines 31-36 and 52-53) and, on the ward, her ability to occupy the student with useful, but small and focused activities, Amelia ensures that the daily caseload is completed, and the student educated, by the therapists best positioned to do so.

c) Preparing for a spectacle of physiotherapy

Within the context of the sections above, which have explored the possible differences in the work practices of the ward and outpatient-based neuro therapists, the similarity with which Lucy and Amelia prepare Verity for her patient-contact time is striking. In Line 40-44 Lucy and Verity enact an interaction sequence that appears to be framed about some preparatory work Verity has been asked to undertake. Lucy’s language in Line 42 suggests that the focus of the discussion is not on patients per se but on their labelled diagnosis and the work of the physiotherapist that is likely to ensue as a result. Verity’s response to Lucy’s expressions ‘Two news’ and ‘Shall we go through them?’ suggests that both the language use and interaction sequence progression are familiar, shared and expected.

On the ward, when Amelia has finished her immediate patient list, she spends time standing at the physio side of the half ward nursing station and prepares Verity verbally for the patient
they are about to see (Figure 1 Lines 119-128). Using a similar question and answer sequence to Lucy, Amelia draws out some elements of the notes Verity has made on the physiotherapy card and helps Verity bring to mind the condition-specific pathologies and assessment practices that she would have learnt at University. Noting that this interaction is the first such that Amelia and Verity have had (as Verity has not been on the ward before this session), it is striking how comfortably they both enact the interaction sequence, an ease with each other illustrated by their shared body movements and eye contact. The extracts in Figure 1 illustrate the usual way that students are prepared for a patient interaction where their learning is the major reason for their taking part in the interaction.

One of the recurring themes throughout the main thesis text is a consideration of the place of the patient in a physiotherapy interaction. The foundations for this are visible in Figure 1 in Lucy and Amelia’s pre-patient preparation and in Amelia’s conversation with Verity. In Line 67 for example, Amelia tells Verity that she is ‘going to do the stairs with Lorna’ while Verity starts the physio record for their new patient. Noting that the ‘Lorna’ referred to here is the ward Band 6 physio, it would seem unlikely that she needs to ‘do the stairs’. Implicit in the statement is both that an unsteady patient will be joining them (unsteady because she / he requires two therapists to be there) and that this patient is going to practise stair walking in preparation for discharge. Similarly in Line 85 Amelia reports that she is ‘going to see another patient’. Again Verity shows no reaction suggesting that she knows that Amelia is not just going to go to a patient’s bedside and look at them!

Thus through Amelia’s everyday use of language and Verity’s complete understanding of it (even on her first time in this work space), we get a sense that physiotherapists describe their work here in terms of doing and seeing, and that what they do and see when with a patient is determined by their understanding of the medically framed diagnosis with which the patient presents.

The typical everyday experiences of third year students on a neuro placement

I conclude this appendix by creating mini characterisations of the scope and focus of the two neuro physiotherapy practice settings experienced by the student. These summaries are intended to act as anchors to help the reader place the discussions in the main thesis document in context.

a) Broad features of the work of neuro physiotherapy in outpatient settings

In the outpatient setting patients are referred for therapy either by medics or therapists from the same or other hospitals. Patients are usually referred to support their transition back into the community when they have been discharged from a hospital setting, or direct from community services to support on-going condition progression (and associated physical deterioration) that does not require a hospital admission. The outpatient neuro team thus acts as a link between hospital and community services and is often attributed with helping keep patients functional and at home. Referrals marked as ‘non-urgent’ are seen by the team in referral date order. With there being no limit to the number of times per week and / or weeks that a patient can attend for treatment (so long as positive progression is continuing), it is difficult to predict waiting list times.

Appointments to the team are made by the team themselves using a diary system of 1 hour slots for a new patient and 45 minutes slots for subsequent follow-up appointments. In reality, slots are booked explicitly to enable cross-over flexibility. Flexibility is necessary partly because of the unpredictable health status of patients (requiring frequent rest breaks) and because many patients attend the service using hospital transport (notoriously unpredictable and often requiring patients to be up, dressed and ready a number of hours before their appointment – compounding issues of fatigue and anxiety).
Neurological outpatient physiotherapy takes place in the neuro office (especially for a new patient assessment or where a patient’s condition demands privacy) or in a therapy area within, but set slightly apart from, the main open gymnasium area. Once a week the team runs a group-based exercise session in the gym for up to 12 patients. The sessions are intended to build individuals’ confidence moving and exercising in noisy and less protected environments. Patients attend wearing their own clothes, but are advised to wear loose clothing, appropriate underwear and comfortable shoes to ease movement freedom and stability.

b) Broad features of the work of neuro physiotherapists in ward settings

There are several linked, but distinctly different elements to the neuro ward therapists’ practice. One of the wards the team covers is surgically-focused while the others accommodate patients with more medical, long-term or sub-acute rehabilitation needs. In the former context patients receiving brain surgery, either for planned or traumatic reasons, are frequently unconscious or semi-conscious in the acute phase of their recovery. The therapist’s role in the acute phase is post-surgical chest and circulatory care. If the patient regains consciousness and movement ability, the team work to support the patient’s re-learning of functional activities such as sitting, standing and walking. When patients are functionally independent, the team liaise with colleagues in other healthcare professions to plan supported discharge home or to a local rehabilitation centre.

If patients do not regain consciousness quickly, then the role of physiotherapy changes because a patient’s immobility places them at risk of chest infections and limb contractures. Patients who are unconscious but medically stable need to experience normal movement patterns in order to keep learned movement pathways viable. After the acute post-operative phase therefore, therapists sit and stand unconscious patients. As may be imagined, this is a physically demanding undertaking that requires two or usually three therapists to work together. Coordinating her team to help each other with these patients was the focus of Amelia’s morning and afternoon team briefings. Neuro therapists thus use their own bodies, often in close physical contact with the patient, to move the patient’s body so that they experience movements that are as near normal to those they would perform themselves. For the more medical patients (i.e. those admitted with changes to their condition or having acute relapses of long term conditions) the therapists help the patient to regain as much movement and function as possible before working with other healthcare professionals to re-evaluate on-going home care support needs.

Ward-based neurological physiotherapy occurs in the patient’s bed area. The bed area is screened off from the surrounding patients using the existing curtains and the area prepared for therapy by the removal of chairs and tables etc. If the therapy requires specialist equipment, for example tilt-tables and walking frames, these are brought to (and returned from) the ward from the outpatient gymnasium by the therapists themselves. Ward-based physiotherapists work with patients in whatever clothing (or not in very acute post-surgical cases) they are wearing or have available. Commonly therefore, ward therapy involves patients wearing bedclothes, dressing gowns and poorly fitting slippers and fits around the equipment of their acute needs for example, air mattresses, urinary catheters, incontinence pads, oxygen tubes, drips, lines and monitoring wires.
Appendix 3: Learning in neuro by co-working with qualified colleagues.

Given the physical dependence of many of the patients seen by the neuro team in both the ward and outpatient settings, it was common for a patient’s named therapist to be unable to treat them on their own. Patients requiring more than one therapist were described by the team as ‘doubles’, with ‘singles’ being those patients somebody could treat on their own. As illustrated in Appendix 2 Figure 1, Amelia coordinated the activities of the ward neuro team through group briefings at the start of every morning and afternoon session, and regularly throughout the day as staff regrouped for note-writing (see for example Appendix 2 Figure 1 Lines 52-53). In Chapter 4 Figure 4.1 Charlotte and Amelia described how their intention, as placement educators, was to give students plenty of opportunities to ‘get (their) hands on’ (Line 21), ‘experience tone’ (Line 34) and ‘have a go’ (Line 26). The examples of student practice explored in Chapter 4 focussed on PEd and patient interactions that appeared to have been set up, at least in part, as learning opportunities for the students. Thus, while in many cases the students have seen ‘doubles’ with their PEds, the interactions have been staged as dual therapy and learning opportunities. In this Appendix I analyse patient interactions (one from the ward and one in the outpatient setting) where the focus was on the patient’s treatment and not the student’s education i.e. patient-contact sessions where the student was present as an extra pair of hands. The first example (Figure 1) presents a typical ward interaction where the student was working as part of a team of three therapists treating one ward patient. Figure 2 records an outpatient-based session where the student was an extra pair of hands for more multiple and more mobile patients in the Balance Class.

a) Co-working on a neuro ward

Figure 1 records the typical multi-therapist interaction for a complex ward-patient. As we walked to the ward pushing the wheeled standing frame needed for the session Amelia explained that she deliberately orchestrated the session to take place immediately before lunch because she knew the patient did not need lunch and the other physio’s urgent caseload would have been ‘dealt with’ already.

Figure 1: Being an extra pair of hands with a neuro ward patient

<table>
<thead>
<tr>
<th>Line</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12.22 pm</td>
</tr>
<tr>
<td>2</td>
<td>Back on Ward. Stuart wheeling frame onto ward.</td>
</tr>
<tr>
<td>3</td>
<td>Amelia has gone to ward earlier. Meet Felicity (rotational Band 5) as we enter.</td>
</tr>
<tr>
<td>4</td>
<td>Amelia appears and all walk to four-bedded unit. Amelia approaches male patient nearest window, Stuart pushes frame.</td>
</tr>
<tr>
<td>5</td>
<td>Amelia resting hands on cot side: ‘X are you alright for us to give you a stand?’</td>
</tr>
<tr>
<td>6</td>
<td>Pt’s eyes are open, minimum response then ‘OK’</td>
</tr>
<tr>
<td>7</td>
<td>Felicity moves to far side of bed, takes down cot side, Amelia does near side and sorts catheter bag, Stuart closes bed curtains.</td>
</tr>
<tr>
<td>8</td>
<td>Amelia: ‘Are you happy if we take your legs and move you over the side of the bed?’</td>
</tr>
<tr>
<td>9</td>
<td>Pt lying on his side, Felicity climbs onto bed kneeling on the mattress (under the sheet) (from the front) swing his head and trunk into sitting.</td>
</tr>
<tr>
<td>10</td>
<td>Amelia: ‘What we need to do is put this strap under your hips so we are just going to be pushing this…… through……’</td>
</tr>
<tr>
<td>11</td>
<td>Amelia puts arms around X and leans backwards to raise buttocks and Felicity directly lifts them (see sketch below). Stuart places sling under patient’s bottom.</td>
</tr>
</tbody>
</table>
Amelia: ‘Right Stuart, when we have him standing you need to fix the straps to here like this’
Amelia: ‘OK X?’
Amelia: ‘Right we need one on the foot, one on an arm and you’ (to Felicity who is still kneeling behind the patient). ‘Stuart you OK on the ankle?’
Amelia hands Stuart an improvised foot wedge she has made from a sheet and shows Stuart how to hold XC’s leg.
Amelia: ‘OK X we are going up… (presses button on hoist). Keep hold of that sling Felicity until we get him up.’
Pt standing in frame. Felicity supporting shoulders and bottom, Amelia with one arm around X’s back and the other holding is painful shoulder, Stuart on the floor supporting X’s foot (see Sketch overleaf)
Repeated cycles of standing, sitting and passive exercises when the patient is on the bed continue until 1.03pm. All three physios help replace crash mats and cot sides by bed. Say good byes. Amelia: ‘Felicity are you alright to wipe down the frame?’ Communal hand washing. Amelia talks to Ward Manager. All leave ward for lunch.

Figure 1 records the typical interaction sequence of a ward based multi-therapist session. As for all other co-working interactions on the wards the most senior therapist lead the session. In Figure 1 Amelia is the therapist who asked the patient questions (seemingly rhetorical) about his consent and compliance with their treatment (Lines 6 and 10), marshalled the other therapists (for example Lines 18 and 20) and took control of the therapeutic interaction by standing near the head of the patient while also supporting the patient’s painful shoulder. Consistently too, the patient’s limbs appeared to be abstracted from him with Amelia in Lines 20-21 allocating ‘an arm’, ‘the foot’ and ‘the ankle’ to her colleagues. Finally, in each multi-therapist interaction the junior therapist moved to the back of the patient and the student to their feet. From her position at a distance from the patient’s ankle, it was unlikely that Amelia could directly supervise what Stuart was doing with the patient’s foot, but her close interaction in the session probably ensured that she would be able to tell if Stuart was struggling to do what she had asked. Unlike learning focussed sessions there were no pre-or...
post-contact briefings or an expectation that the student would write the session notes (Lines 33-36). Thus the interaction sequence in Figure 1 suggests that, while student's education per se was not the focus of multiple-therapist treatment sessions, students would have experienced physiotherapy practices of patient communication, cross-team patient-present communication and work differentiation based on seniority through them.

b) Co-working in the neuro outpatient setting

Once a week Julie led an outpatient balance class for up to eight patients. The session was set up loosely as a circuit to enable patients to gain more confidence in performing daily functional activities which may have become more difficult following the neurological problem for which they were initially admitted for inpatient care. While some patients brought carers to help them, others came alone and require therapist input in an exercise-supporting role. In On the day observed for this study both Lucy and Verity provided this support but, not being given any more information about the patients or their role, appeared at a loss as the patients began to arrive. When the class started, Julie, who knew all the patients well, asked Verity to help with one specific patient. Figure 2 presents an extract from the field notes which illustrates the challenges of being a student and an extra pair of hands in an exercise class environment.

Figure 2: ‘Helping’ with an outpatient exercise class

The short field note extract in Figure 2 captures the midway point in the exercise class. Verity’s patient had been sitting out resting between each station on the circuit. In Line 2 Verity leads the patient to a station that involves balancing on a wobble board. The patient has hard shoes on (making feeling the board difficult) and carries a stick in one hand. The patient manages the first activity satisfactorily (Lines 4-5) and Verity, not knowing the patient, progresses (or makes more difficult) the exercise with the result, in Lines 6-8, that the patient nearly falls. The balance class is a typical example of a setting where the senior therapist co-ordinates the class, sets up the stations, times and moves patients through the stations, but has little time to monitor their individual progress – or the activity of the student ‘helping’ them. As with the ward scenario in Figure 1, there was no post briefing or expectation that Verity would help write the patients’ notes following the class.
Appendix 4: Making sense of MSk Placements: exploring the access interviews.

**Attempting to make the strange familiar: the ethos and aims**

By the end of my first departmental access interview I had a sense that the MSk placement would offer students very different learning opportunities from those experienced by the neurology students, not least that there would be two students possibly working together around a timetable structured and defined for them in advance. As the meeting with the Placement Education Duty Leader closed, Ian commented that the placement was deliberately organised so that ‘students do not “mimic my mentor”’. With no time to unpack this remark, I focussed my second access meeting much more closely on the specific practices of placement education at this site. The second interview was with Megan and Naomi who, in Ian’s words, were ‘the guys who share the timetable planning’. This Appendix uses the audiotape transcripts from this joint interview to explore how Ian’s vision is turned into a placement timetable. In addition, because Megan and Naomi took students in their turn, they were able to give me specific examples of placement teaching practices and thus foreshadowed the type of activities I would need to capture in my field notes.

**The nature of the physical work environment**

Megan and Naomi worked in the same ‘Treatment Room’ in the MSk Department and chose to use one of the cubicles for our meeting. Naomi reported that a mirror image of this room layout was found in the other Treatment Room, and that this other space ‘is where the students live’. This was my first time in such a space and provided an opportunity to reflect on how I felt in this environment.

I was very anxious about my meeting and felt the environment and not the therapists augmented that anxiety. My anxiety about the interview arose both because I had not met Megan and Naomi before, and because MSk was not a speciality I had felt comfortable with as a practising therapist. This latter however, was well known at the site, and affected the interview positively with both Megan and Naomi trying to make sure I understood what they were explaining before moving the conversation on (as will be illustrated below, this interview contained far fewer assumptions of a shared understanding than my interview with the neuro team). Spatially however, I was acutely aware that I could hear everything through the curtains about what was going on in the adjacent cubicle (and thus they our conversation), that the radio was loud (although Naomi turned this off when our conversation began), and, with the room set up so that the plinth was a ‘table’ between us, how small the space was – and how close the two ‘interviewees’ were to me. Even fully dressed (unlike patients would be) and invited into this space, my field notes record my vulnerability and sense that I had nowhere to ‘go’ to change the spatial layout of this physically close interaction. Megan and Naomi however seemed comfortable in the environment. The speed and flow of conversation evidenced in the interview extracts that follow, suggest that both therapists shared common understandings about the activities they described and an easefulness in each other’s presence.

**Creating a timetable from a vision**

At the start of our access conversation Megan took the lead answering my questions and turn-taking was evident. As the conversation progressed however the pair talked over each other, adding ideas, extending the discussion etc. In the transcript extracts that follow, the messiness of the interaction has been left in to illustrate the level of agreement between the pair. Where appropriate in the discussions that accompany the data, I make comparisons between the responses of the MSk team and the related conversations I had with the neurology team leaders Amelia and Charlotte.
To open the discussions I invited Megan and Naomi to talk about their personal aims for placement education. Readers will remember that, in the neuro access discussion meeting Amelia and Charlotte described their aims for a student placement in terms of ‘demystification’ and ‘confidence building’ and then progressed quickly to talk about how the placement was constructed to enable students ‘to get as much hands-on’ time with patients as possible. Figure 1 illustrates Megan and Naomi’s thoughts about placement aims.

Figure 1: The personal aims of placement learning held by the placement planners (underlined words indicate verbal emphasis)

1 Megan: ‘The first thing is to make sure that they are confident in seeing a range of 2 musculoskeletal pathologies.. umm.. you know if we are trying to make them into well 3 rounded clinicians.. to not scare them off really.. I mean surprisingly, with my 4 musculoskeletal placements, my second one was horrendous.. um.. but, I think my 5 experiences in, as a junior, were more reassuring for me.. um.. yeah.. so confidence was 6 one thing and.. and.. kind of, exposure to a wide range of patients.’
7
8 Naomi: ‘I think, like particularly with the Year 3’s, you are like, really preparing them to work, 9 so like bridging the gap really between Uni and, you know.. the classroom set-up.. to the 10 patient.. umm.. you know.. the set up in hospitals and working 5 days a week.. umm..so 11 yeah.. particularly with Year 3’s, um.. yeah, in every way, you know, clinically in terms of the 12 way they talk to patients, listen to patients in terms of...umm.. how they manage their time, in 13 terms of how they write the notes and.. all those things.. talking to the medical profession 14 ..yeah....so I guess, yeah.. putting into practice really.’

The data referred to in Figure 1 suggest that Megan’s aims for a successful student placement reflect those of her neuro Band 7 peers. While Amelia wanted students to get plenty of hands on experience with patients, and Megan wants the students to get ‘exposure to a wide range of patients’ (Line 6), their overarching intention is that students should use these experiences to gain confidence in the management of patients sent to their speciality. In contrast, and perhaps reflecting her more junior status (and thus the recently rotation-based nature of her own employment experience) Naomi’s aims are more task-focussed and can be itemised into visible work practices (see Figure 1 Lines 12-14).

The dialogue in Figure 1 occurred 11 minutes into our 57 minute interview and illustrates the only explicitly similar element of the neuro and MSk access interviews. The rest of this Appendix traces the themes that arose during the MSk discussion. The attention to detail here is important because Megan and Naomi’s words and practices during our interview foregrounded explicitly the placement education practices I would observe. By contrast, readers will remember that when I left the neuro team interview I had little specific idea about the education practices of the team and thus spent the first day in the field trying to get a sense of what I later described as ‘the blur of practices’ I observed.

Having expressed their personal thoughts about the aims of the student placement they offered, Megan and Naomi turned the conversation to the structure of the local MSk placement and their personal roles in setting it up. While Ian was never mentioned by name, it is clear from the transcript extract in Figure 2 that the placement vision he articulated underpins their activities. The first challenge for ‘the guys’ was to allocate the PEds to each placement. As indicated in Figure 2, this was no small task and played a major part in influencing the placement learning experiences that were available to the visiting students.
Megan: 'Well, we’ve.. we get two [students] always ..um.. so that’s the first thing.. um.. we always get two new students and they work together.. um.. and.....the first difficulty is to find enough clinics that are free, because, we don’t.. some places.. um.. the students have patients along and the physios have patients alongside but, in our department we actually don’t have a list while we are with the students, so we, we dedicate ourselves to them, because there are two of them, we dedicate ourselves to those two students for the period of time that they are seeing patients.... because we do that we have to find.. like a set.. we try to get three clinicians.. um.. to work with them on that basis and we have to identify the clinicians that will be free for that time, so that is difficult.. um.. but once we do that then we have to obviously take into account their duties, so for example, if they are in a class then we will try to make sure that the students… do that and then the same with hydrotherapy, so if hydrotherapy is on the diary for that week, and hydro’s usually twice a week, that they do their duty twice a week … depending on who the clinicians are, depends slightly on what the students get exposed to, so if the clinician doesn’t do hydro or if the student’s not with them when the hydro’s on, then they won’t do hydro or classes or whatever.’

Naomi: ‘We usually try to have a Band 7 and two Band 6’s.. that’s usually how we like to weight it.. um.. and we ..all the Band 6’s and Band 7’s are on the ..list of people  that we take to do it, it’s not just a core number of physio’s that are doing it. Because we get.. this year, we are getting 16, and a lot of them are back to back.. umm.. so if one person was to see them all of the time then they would never  see any patients.. umm’ (Megan: ‘Yes’ quietly)

Naomi: ‘I just think that seeing patients is the core. I think the classes and hydro is an extra – an additional thing. And if .. if.. (Megan: ‘for some patients stay an hour or an hour and a half’) they might get exposed to one of these three things [clinics, hydro, classes] but if they don’t, we don’t kind of change things around really to make that happen because it’s not.. (a) it’s practically very very difficult and (b) it’s not.. it’s an optional extra, it’s not essential.’

The interview extract in Figure 2 makes visible the administrative complexities of turning Ian’s placement vision into practice. The way that Megan uses the phrase ‘we dedicate ourselves to them’ (Figure 2 Lines 5 and 6) suggests that she is both supportive of the idea of ‘dedication’ and understands Ian’s meaning of the word in this context. While acknowledging their support for the underpinning placement approach, it is clear that Megan and Naomi are faced with a challenge to find ‘a set’ of educators every four weeks and, from the set divide their dedicated PEd days to create a weekly pattern. The repetitive administrative (and not learning focussed) approach to the timetabling activity is apparent in Figure 2 as Megan talks impersonally about the visiting students (i.e. ‘we get two always’ Line 1) and her repeated use of the word ‘difficulty’ (Lines 2 and 9). For every placement therefore, Megan and Naomi had to create an onscreen outline four week timetable for each student, allocate a PEd ‘set’ while taking account of staff leave and junior staff rotations, and block off ‘dedicated’ days into the onscreen diaries of the three therapists in each educator ‘set’. The latter had to be done early enough to prevent the PEds booking patients into their PEd days. Recognising that about 20 staff were available for PEd allocation and that each had a different ‘duty’ combination makes clear both Megan and Naomi’s challenges and the diverse learning opportunities potentially available to the students.

It is notable in Figure 2 however, that both Megan and Naomi articulate a perceived hierarchy in the value therapists place on the two elements of their role – with the ‘duty’ implicitly less important than the ‘core’ work. This access interview was the first sense I had of such a work distinction. It is important to recognise that implicit in Figure 2 Line 10 is the understanding that, while the PEds drop their ‘core’ work for the days they are acting as PEds, their duty roles continue. Thus, in a system where PEds are dedicated to their
students, the ‘duties’ were one of the few times in the students’ placement when they saw their PEds at work with patients. In this way the placement timetabling activity appears to build an unintentional (and invisible to the students) tension into the students’ learning opportunities i.e. the times students see their PEds at work are those times that the PEds may least value their work.

*Building consistency into the timetable through ‘techniques’ and ‘clinical reasoning’*

During our interview Megan and Naomi described two ways in which they tried to timetable consistent learning experiences for all students across MSk placements. Notwithstanding the ‘duty’ roles of their PEd team, all students had allocated sessions for skills and clinical reasoning development built into the timetable. The interview extract with Megan in Figure 3 illustrates how the timetabling of skills practice is achieved.

Figure 3: Core placement learning opportunities: Techniques and skills practice

1 Megan: ‘In the first week they will have.. the majority.. they have an hour each day when
2 they do their own *practice*, which is led by themselves so they spend an hour, in fact,
3 practising techniques ..um. ..on each other so they will do that and we would encourage them
4 to check the er.. patients they have got the next day so that they can practise in the morning,
5 assessment techniques or treatment *techniques* that they might use for those patients, and
6 we do stuff with them if they have cancellations, we don’t have a set time where we do stuff
7 with them. They come to technique sessions which are twice a week and they practise
8 techniques that.. usually every month, we have a theme.. um.. like a certain area of the body
9 so it may be neuro, lower limb, or cervical spine, passive accessories.. (Naomi: ‘It's not just
10 our department we all of us do it...it’s, well it’s just somebody saying OK... we’re going to
11 practise PVMS on L4’).. and one person leads it, and then we practise it and then we might
12 have, like, some clinical reasoning and things surrounding it, some case scenarios, or, that
13 sort of thing. And they do that twice a week.. um.. for half an hour each (CK: ‘You all do
14 that? Sorry’) yeah, but they do it with us ..’

Not only does the interview extract in Figure 3 illustrate the anchoring of ‘techniques’ in the students’ weekly timetable, but it also offers insight into the implicit value systems and MSk physiotherapy practice philosophy at this site. From Megan’s perspective the twice weekly technique sessions were opportunities for the whole MSk team to practise skills framed about a theme and patient scenarios (Lines 9 and 12). Naomi’s interjection (Lines 9-11) suggests that, from the perspective of more junior staff, the sessions are for group practice of more distinct, isolated skills. Naomi’s choice of technique example (‘PVMS on L4’ Line 11) is also interesting and seems to be doing more work in the interaction than simply acting as an exemplar. Not only does her language use suggest that she assumed I would understand what she was talking about, but also, understanding it as I did, I was perhaps being led to see that the techniques they practised were more challenging than skills I might have thought they were talking about.

Through both her language and choice of example (which was not corrected or qualified by Megan) Naomi is heard laying claim to a complex skills set that I, as a former neuro therapist, would be unlikely to possess. This apparent claim to expertise is further evidenced in Figure 3 Line 12 by Megan’s expression ‘clinical reasoning and things surrounding it’. As described in the main thesis text, clinical reasoning is the name given by physiotherapists to the thinking processes they use to work out a patient’s physiotherapy relevant presenting problems and create an appropriate treatment. Higgs and Jones (2008) define clinical reasoning as the way that physiotherapists:
‘process multiple variables, contemplate the various priorities of competing healthcare needs, negotiate the interests of different participants in the decision-making process, inform all decisions and actions with advanced practice knowledge, and make all decisions and actions in the context of professional ethics and community expectations’ (p 4).

In the context of the current study, the term ‘clinical reasoning’ is present as a broad term in the University’s placement documentation as both an ‘Intellectual skill’ based generic learning outcome and the overarching title of the end of placement assessment proforma. Referring back to the fieldwork and interview data from my observations with the neurology placement team, the term ‘clinical reasoning’ is only used three times in my whole data set, and each time by Amelia in our post observation interview as she explained what she was trying to get the students to think about in the post-patient contact de-brief sessions I had observed. During the real-time neurology placement ‘clinical reasoning’ as a term was not linked explicitly to any practices I observed. The appearance of the term at the point of her final interview resonates with Garfinkel’s ideas about social group members ‘accounting’ for their practices and actions. Garfinkel (1974) uses the terms ‘accounting’ and ‘accountable’ to describe ‘that peculiar way of looking that a member has…[for] making practice observable and notable’ (p 17). The interview data suggest that Amelia is accounting for the placement experiences her team offers students in a language that aligns with the documentary requirements of the University. The sudden appearance of the term ‘clinical reasoning’ in this final interview perhaps illustrates Amelia trying to make her everyday activities observable and reportable (and potentially thus more valued).

In contrast, while Figure 3 illustrates its first use, ‘clinical reasoning’ was used ten further times in this MSk interview. Prompted by the visibility of the term, I asked Megan and Naomi what ‘clinical reasoning’ meant in their context and the emphasis on it within the MSk placement they offered. As the data in Figure 4 and discussions make clear, clinical reasoning is an explicit feature of the MSk placement learning experience here, and as such impacts directly on the way the students’ daily timetables and work practices were structured.

Figure 4: Interpreting clinical reasoning and its impact on placement learning timetables. (Words underlined illustrate verbal emphasis)

<table>
<thead>
<tr>
<th>Naomi: ‘We’ve had an on-going issue about.. umm.. uh.. problem solving versus clinical reasoning. We.. er..we teach them to clinically reason, whatever their level.. you know.. and it’s a big aim for the whole of the ..placement ..for them to get at the end of it, well, to be clinically reasoning.’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Megan: ‘Clinical reasoning is, we go through a process of..you know.. kind of identifying pain mechanisms, so what pain mechanisms might be going on so.. um.. so if it was something like arthritis, it would be inflammatory.. um..if it was something.. kind of.. with nerve problems referred from the neck then peripheral neurogenic. Umm so.. trying to identify the, kind of, severity of, irritability and nature and the pain mechanisms that are going on first, to then be able to use that to question the patient about their types of pain and fit the two together ..and then to go on to consider the source of the symptoms so.. with relation to ..kind of.. because of the mechanism.. it’s almost like why are you asking the questions you are asking? What is the information giving you towards a pain mechanism or a possible source? Obviously it’s something that they’ve never, as a 1st year or 2nd Year in their first placements .. they’ve never done that sort of thing before.. but we try to encourage it because otherwise it’s all about guesswork if there’s no clinical reasoning really, and even 3rd Year students who’ve had a previous out-patient ..um.. placement may not have been used to clinically reasoning in that way, so we do spend quite a lot of time in the first week establishing that format really… It’s a hypothesis, it doesn’t have to be a (Naomi: ‘Problem’).</td>
</tr>
</tbody>
</table>
definition.. it doesn’t have to be definite, that’s what it is.. you know. Over time you may actually.. you know.. rule that out, or you may change your hypothesis.’

In terms of, in terms of structure... for all of them new patient time is an hour and follow-up time is half an hour.. um.. there is quite a lot of.. kind of flexibility to be able to write notes outside of that time, because we have half an hour feedback time following each new patient which is where the clinical educator and the students sit down and either like, clinically reason the patient a bit more, or, give the student feedback on how they have done and how they can do better. So there is always time then to chat through the patient and there is generally quite a lot of...their diaries are rarely back to back full... so there’s normally time for them to complete their notes outside of that hour that they have had.’

Naomi: ‘So, so say, Johnny will see his new patient and the clinician and the other student will watch that going on. Generally, after the subjective, we will take them out and have a bit of a chat about what is going on, plan the objective, go back in, they do that, sometimes after the objective, they come out and have a little chat about planning treatment and they go back in, do that, and then send the patient away and then we will all sit down together.. and just chat through that process and then, Johnny the student, will then see that patient again as a follow-up. Further down the placement they might both have new patients at the same time (Megan: ‘So then we wouldn’t go in so we are not in with it the whole time’), and then they just come out and tell us after the subjective and what they have found and we will reason.. with them.. (Megan: ‘You might chose to go in with one one day or.. you know.. or one on one patient and one on the next and the same with the follow-ups really so the follow-ups are not always watched.’).

The extended interview extract in Figure 4 follows Megan and Naomi’s conversation as they explained what clinical reasoning meant in this MSk setting and the education practices they employed to teach this to their students. Figure 4 suggests that, unlike in the neurology context, ‘clinical reasoning’ is a common term used explicitly by the MSk team to ‘account’ for the physiotherapy in their practices (Garfinkel 1974, p. 17). The local MSk team are so committed to their interpretation of clinical reasoning (and the physiotherapy practices that they think flow from it) that they are prepared to have an ‘on-going issue’ about it with the University department (Lines 1-4).

Figure 4 Lines 6-22 suggest that the MSk team at this site prioritise the hypothetico-deductive model of clinical reasoning. In Lines 11 and 14 for example Megan appears to be implying that patients are asked a series of questions with their answers informing the subsequent direction of the therapy interaction. This practice suggests that the control of the interaction lies with the therapist and does not provide explicit opportunity for patients to tell their own narrative. In addition, Megan’s words illustrate a step-wise thinking process that appears to be located in a scientific (suggested by the word ‘hypothesis’) or biomedically-informed (suggested by the use of words and phrases that appear to remove the patient as a human from the interaction) practice framework.

The data in Figure 4 also suggest that the MSk team think that their ‘format’ (Line 20) for CR development is better than the way students may have been taught on other MSk placements (Lines 16 and 19). The team’s emphasis on, and valuing of, their format for CR education is further illustrated in Lines 33-44 as Naomi explains local PEd practice. In describing the broad patient assessment process Naomi uses similar words to those used in the neuro placement setting. Thus, in both contexts, the first phase of the patient assessment is the ‘subjective’ assessment (Lines 34, 41) and this leads to the physical or ‘objective’ phase (Lines 35, 36). Placement education practice however differs between the settings. Perhaps because their patients are physically well, Naomi foregrounds the MSk PEd practice of removing the students from the patient at least once and usually twice in an assessment interaction. As suggested in Figure 4 Lines 35 and 36 students come ‘out’ (of
the cubicle) for clinical reasoning practice before ‘going back in’ to put the ideas generated away from the patient into practice. Thus, while PEds in MSk appear to mirror their neuro peers’ use of pre- and post-assessment briefings (Figure 4 Lines 37-38), the MSK team conduct CR sessions away from the patient. In contrast the neuro team talked about what they are thinking in front of, over or behind the patient.

Finally here it is important to explore Figure 4 Lines 24-31 in which Megan explains how CR education is diarised. Recognising that qualified therapists are allocated (by the centralised booking system) 45 minutes for a new patient assessment, Megan’s comment that students have an hour (Line 24) could be seen as accommodation for practical slowness that may be expected due to students’ lack of assessment expertise. As Megan continues however, it becomes clear that the extra time allocated to student new patient assessments accounts for CR time away from the patient. Students on this placement must therefore align their practice to the local work expectations in a fixed diary system and, as illustrated in Lines 25 and 30-31, manage their non-patient contact time to complete patient related activities. Just as we saw in the neurology placement, note keeping is a core practice activity. On the neuro wards students and other therapists engaged in frequent short bursts of note writing activity in-between patient contact sessions. The suggestion in Figure 4 however is that, for MSK staff, note writing must be accounted for within the diarised patient slot to avoid a backing-up of tasks. While it is clear that Megan feels the students’ timetables they provide offer space for additional note writing time outside that specifically diarised, the implication that work practices are closely linked to effective time management is clear. This last observation is relevant in the context of clinical reasoning because Trede and Higgs’ study identified time constraints and caseload pressures as key determinants in why physiotherapists adopted diagnostic rather than narrative models of reasoning (Trede and Higgs 2008).

In this Appendix we have seen how local organisational accountability (in terms of patient throughput, record keeping and central diarisation), together with team-specific privileging of techniques practice and clinical reasoning development, combine to frame the learning opportunities that are available to students. In addition, Figure 4 has made visible some of the challenges that face students visiting a placement. While all students will be assessed at the end of four weeks against criteria that are consistent across specialities and placement sites, local expectations and accountability frameworks may impact differently on their learning potential. From these access meetings it became clear that a key focus of my observation had to be how students were helped to assimilate into, and maximise their learning from ‘the complex web of relationships, material artefacts and activities’ that make up ‘the texture of practices’ at this site yet may differ from those of their previous experience (Gherardi 2006, p. 2).

Creating learning opportunities: the place of the patient

In the neuro placement observed for this study, students’ access to patients was managed by the PEds and influenced both by the daily patient: staffing level mix and the PEds’ deliberate selection of ‘cases’ to expose students to specific neurological pathologies and related therapeutic interventions. Early in the neuro access interview it became clear that students worked alongside their PEds, and as such, especially when workload was high, tended to access patients who needed the input of two pairs of hands. Thus neuro students tended to work with the ‘doubles’ or ‘complex’ patients on the wards, and with patients that had been specifically selected for them in the outpatient setting. In most cases the neuro PEds appeared to be ‘creating a spectacle’ of physiotherapy from the ‘manipulation of everyday objects’ – or, in this case, the available patients’ conditions (Lynch and Macbeth 1998).

In contrast, the MSK access interview with Megan and Naomi suggested that patient selection was the least important element of the placement planners’ role. As illustrated by
the final extract from the access interview (Figure 5 below), once the timetable framework and the PEd set had been organised, the role of booking in new patient assessments for the first week of the placement fell to the departmental administrator.

Figure 5: The role of the placement planners and PEd set in patient selection

| 1 | Megan: ‘Umm.. when there is a new patient ..we have to classify them as acute, sub-acute |
| 2 | and/or routine.. um.. whether they are an upper limb, lower limb, spinal patient, whether they |
| 3 | can be seen by anyone.. um.. which is broken down into students, yes or no, or whether they |
| 4 | have to be seen by a senior. So they have been highlighted... so we prioritise everyone in |
| 5 | the Trust... recently I changed it so that it was  ... basically we classify the post for the entire |
| 6 | Trust in terms of out-patients, so all of, every patient.. new patient referral that comes into |
| 7 | our department .. we have to classify them all for the Trust, because there is a central kind of |
| 8 | point and central list.. um.. and now, we have put on “student”,” yes” or “no”, so the entire |
| 9 | Trust gets that and it is up to them whether they chose to use it or not and then, it should be, |
| 10 | it isn’t always, because it’s not always within our control, it’s the admin staff, and then it’s |
| 11 | literally only the patients who have yes or no on them that get booked in on their diaries.’ |

Figure 5 illustrates the process by which patient referrals are organised and managed across a wide geographical area and number of MSk outpatient sites. This categorisation was the focus of Megan’s second duty. Megan’s role was to label the received referrals with respect to their perceived complexity for students and other staff. Thus through her duty Megan transformed the referral letters into cases labelled by perceived therapeutic urgency, complexity and problem body part. Once patients’ referral cards had been labelled they are stacked in priority order in the electronic waiting list. The departmental administrators then worked through the lists allocating patients to available online diary slots. With no oversight of the process it was quite normal for students to have new patients at the same time and to have caseloads that lacked condition variety. The only consistent patient bookings across both student diaries were on the first day of the placement. Following ‘induction and objective setting’, each placement started with the students watching their PEd performing a new patient assessment so that, in Megan’s words ‘they see how we do it here’. Having observed their PEd in action, the students would spend the rest of their first day taking turns to assess a new patient while the other student and PEd watched. Student observation of each other’s assessments and sitting in on the away-from-patient CR briefings were encouraged but not planned for activities for the rest of the placement.

Appendix summary:

The second MSk access interview gave me the opportunity to experience being in a treatment cubicle. I used this insight to ensure that I prepared for my field work by being able to take field notes while neither taking up much physical space, nor drawing attention to myself through rustlings and other noises. By the end of the access interviews it was also clear that this MSk placement was underpinned by a specific vision of learning outcome, and that the way this vision was turned into practice impacted on the types of learning experiences that were available to the students.
Appendix 5: Learning a different face of MSk physiotherapy: the Hydrotherapy experience.

Introduction

Hydrotherapy is the therapeutic use of water to assist a patient’s rehabilitation. Hydrotherapy is performed in different ways across physiotherapy practice. In this study hydrotherapy took place in a large warm therapy pool with four different internal depths and railings. The deepest area of the pool enables people to be covered in warm water to their shoulders when standing. Along the edges of the pool are floats, water weights and, in one corner, a small pile of physiotherapy notes. Hydrotherapy is a ‘duty’ and Belinda (Band 7) is the duty leader supported by 5 Band 6 colleagues. Each therapist ‘covers’ a different hour-based therapy slot and, when the therapists have students with them, these attend the pool with their PEds. Hydrotherapy thus provides the main opportunity for students to see their PEds in patient-facing interactions.

Patients are referred to hydrotherapy by the departmental MSk staff who complete a short card outlining the reason for the referral. Unlike the on-land provision, hydrotherapy is offered in ‘courses’ of six sessions. These sessions are diarised to suit the patient and thus they rarely see the same ‘duty’ therapist twice. Observation suggests that the role of the therapists in the pool is to monitor and develop patient’s individual exercise routines. With one therapist and up to six patients in the pool at any time, the therapists rotate about each patient several times during the 40-45 minutes that patients stay in the water. The lynchpin in maintaining a smooth and coherent experience for the patients is the physiotherapy assistant. This full time assistant (non-qualified therapist) coordinates patients’ appointments and provides the qualified staff with the attending patients’ notes and progress synopses.

In this Appendix I illustrate the specific challenges facing students, patients and therapists in the pool context, and the consequent adjustments in their interaction practices that result. Readers will remember that Megan and Naomi considered the students’ attendance at, and participation in, duty-related activities as an added extra in their placement experience and thus not ear-marked as opportunities to help students learn anything in particular. Analysing the hydrotherapy dataset from a situated learning perspective suggests that the environment offers powerful affordances for learning.

Gibson, an American psychologist interested in understanding human perception, adopted the term ‘affordance’ (Gibson 1977). Gibson argued that the environment and animals (including humans) have co-evolved with changing features of the environment affording (enabling) different forms of animal perception and action in it (Boyle and Cook 2004). Deriving his term from the word ‘afford’ or provide / enable / make available, Gibson developed the word ‘affordance’ to describe what the environment (or an object within it) affords to the animal (Gibson 1977, p. 67). Gibson suggests that ‘an affordance is not bestowed upon an object by a need of an observer and by his act of perceiving it. The object offers what it does because it is what it is …. The affordance of something does not change as the need of the observer changes’ (p. 78). Sharrock and Coulter (1998) extend Gibson’s ideas of ‘affordance’ and suggest that to see an affordance in an object or environment requires learning. Thus ‘affordances are organism relative functionalities’ (p. 153) because ‘we do not ‘get the world’ only out of perception but out of socialisation, education, training, practice… we have to be taught to identify bananas as edible things’ (p. 155). In the context of a discussion of student MSk placement learning, the physical features of the hydrotherapy environment create an affordance or ‘the possibility for a certain kind of behaviour’ (Laurillard et al. 2000, p. 2). This Appendix explores the affordances of the hydrotherapy interactions and discusses the forms of interaction and learning experiences that ensue.
The structure of hydrotherapy practice.

Using the same interaction phase descriptors to analyse the ‘core’ and hydrotherapy MSk placement datasets suggests that physiotherapists in both settings undertake therapeutic interactions using the same sequencing structure but that there are different emphases placed on the various interaction phases. As illustrated by the composite placement activity mapping in Figure 6.14, the cross-MSk analysis suggests that practices in the pool place less emphasis on patient specific data collection (both subjective and objective) and greater focus on exercise teaching and modification. In none of my data were students prepared either for the shift in emphasis of their hydrotherapy session, or the role that they were expected to play in this setting. Figure 1 collates two students’ reflections on their hydrotherapy experiences.

Figure 1: Interview transcript extracts of John and Louise’s reflections of their hydrotherapy experiences.

John: ‘I had a new patient and….I hadn’t a clue what was going on. And it’s not like, you know in outpatients where you get subjectives, you figure out their personality a little bit and what’s going on. And in hydro you’re just faced with a person you’ve just got to get on with it…..My new patient yesterday it (the referral) said, I think it just said ‘knee pain’ perhaps, ‘leg pain’ maybe? So I was like ‘how do I do a subjective assessment in a pool to find out what’s going on in order to treat her within half an hour when I’ve got 2 or 3 other patients’, like this is really difficult and hard and not very fair on the patients at all’.

Louise: ‘You have to think a lot more because you’ve got to like, figure out which way is resisting more, and all of that. But I find once, I don’t know, I was a bit rusty the first time, but now I’ve had my last week, I was like “oh I can do that and do this” and just kind of experiment and see. And also patients kind of get a favourite exercise, so you’re like “what exercise did you do last week that you liked and that you felt worked a lot?”

The extracts in Figure 1 illustrate the impact on students of an environment where situated learning is the consistent but unarticulated pedagogy. John’s comments suggest that he had not realised that the hydrotherapy treatment rationale differed from that which he was being taught during his dry-land patient contact sessions. John expressed concerns that suggest he was struggling to find the physiotherapy (i.e. the form of physiotherapy he thought the local site privileged through their dry-land patient facing activities) in his pool-based interactions. In contrast, while Louise did not articulate her reasoning, she clearly perceived the affordances of the hydrotherapy interactions and the greater opportunities for practice experimentation available to her.

Some insight into the locally perceived role of physiotherapy in hydrotherapy is illustrated in Figure 2. In response to a patient’s comment that it was her last hydro session, Belinda, the duty lead, offers information about other opportunities for the patient to continue with warm water exercise.

Figure 2: Field note extract of a pool-based conversation between Belinda and her patient.

Belinda’s pt’s last session: ‘I will miss this.’
Belinda: ‘Well you can come in the evenings. They’re not physio sessions, just exercise classes really, but really good.’

Analysing the full data set of the students’ time in the pool with Belinda suggests that, in common with the other qualified therapists I observed performing the hydrotherapy duty,
Belinda divides her time in the pool between the patients and moves around each in turn. Unfamiliar with most patients, the therapist asks how the patient is ‘getting along’ and then observes and progresses, as appropriate, the range of exercises they are performing and self-pacing. Belinda’s response to her patient in Figure 2 Line 2 suggests that, while physiotherapy-led hydrotherapy sessions are exercise focussed, the value-added of having a physiotherapist in the pool is their ability to customise and progress exercise to suit individual patient’s needs.

It may be this change of emphasis from a dry land environment focused on clinical reasoning to pool-based practice focused on individual exercise monitoring and progression that Louise spotted and relished but John missed. The consequence for John was a learning environment where he felt stressed and performing poorly in his attempts to treat his patients. The interview extract in Figure 3 however, suggests that, while some features of the environment remained concealed to John, he was acutely aware of others.

Figure 3: John describing aspects of the hydrotherapy environment that he did perceive.

‘I had a new patient come in the pool, so I thought ‘new patients they need a lot of attention because they’ve never been to hydro before, there’s lots of people around, they are aware of themselves being in a close environment, all that stuff’… and she was a lady as well, so I thought ‘okay’…. and they are half naked… yes it’s weird’.

The data in Figure 3 suggest that John perceived major environmental factors that influenced the performance of physiotherapy in the pool i.e. that the therapists and the patients are working in close physical proximity to each other, that they barely know each other and that they are all in their swimwear. At no time did I hear, or students suggest, that the environmental features of hydrotherapy had been discussed with their PEds. Despite the lack of explicit teaching in hydrotherapy practice performance, the conformity of the students’ and PEds’ practices in the pool recorded in my data are striking. The section below illustrates and discusses the affordances of this powerful situated learning environment through a discourse of bodywork.

Physiotherapy body work: the special case of hydrotherapy.

The main thesis text has explored the concept of bodywork within MSk physiotherapy practice and the strategies students appeared to use to ‘transform’ the bodies of their patients into ‘appropriate objects of labour’ and in so doing distance themselves (and by implication the profession too) from the intimate nature of the work being performed (Twigg et al. 2011, p. 179). While Twigg et al and Emerson (1970) discuss the challenges for patients and therapists of negotiating strategies to deal with these ‘matters out of place’ in a therapeutic interaction (p. 172), the boundaries of socially agreed body distance require renegotiation when both the patient and the therapists are in their swimwear. John and Gareth reported being acutely aware of both their state of undress and that of their patients as illustrated in the extracts from their post-observation interviews in Figures 3 and 4.

Figure 4: Male students’ reflections on the hydrotherapy body work.

Gareth: ‘I don’t know if it’s a gender issue but I think in hydro I have been a bit more stand-offish in general because there’s a state of undress involved. And I think I’m not sure where the boundaries are about being hands-on, I have been hands-on, I have kind of, but asked about palpating trans abs (stomach muscles), but I think I just need to be more conscious of it.’

Remembering that all the PEds and other students observed for this study were female, it is noticeable that only the male students raised the issue of mutual patient: therapist undress.
Despite the lack of an explicit sense of ‘noticing’ that the boundaries of therapeutic interactions may have changed in the hydrotherapy context, the proxemics sketches across the whole hydrotherapy dataset suggest that all therapists and students appeared to adopt the same ‘in pool’ bodywork practices to repair the interaction on account of the participants’ mutual state of undress. Here I identify three strategies that work to increase the physical distance between the patient and therapist during pool-based interactions.

i. Directing exercises without the use of hands

A remarkable feature of the hydrotherapy proxemics sketches is the limited physical contact between patients and therapists. The physical properties of water can be used to assist and resist movement through the use of weights and floats attached to the moving limb. As anyone who has tried to stand up and exercise in water will know, balance is a substantial challenge. In these sketches patients are being asked to balance with light support from a handrail while simultaneously isolating their movement to the joint being ‘treated’. It is remarkable that no sketch in my dataset captures a student or PEd physically supporting a patient while they move. Indeed as illustrated in the sketches below, it was usual practice for students (Figure 5a Louise) and PEds (Figure 5b Belinda) to stand with their hands behind their back while patients exercised.

Figure 5: Physiotherapists at work in a hydrotherapy pool: an absence of physical contact.

![Figure 5a: Louise observing her patient perform knee bends while using a float.](image1)

![Figure 5b: Belinda (with arms behind back) talking to Gareth (on his knees) and patient.](image2)

ii. Talking to the patient

Another hydrotherapy practice that differed from that observed during ‘core’ dry-land MSk physiotherapy was the place of the patient in a PEd: student interaction. Figure 6 records the proxemics of Belinda’s interaction with Gareth and his patient. Unlike Belinda’s patient-present verbal and proxemics interaction with Gareth during a dry-land new patient assessment (for example see Figure 5.14), in the pool Gareth is side-lined as Belinda explicitly talks to the patient. This pool-specific PEd practice of talking directly to patients with plenty of eye contact, and no physical contact, was typical.
iii. Not looking at each other’s body

Given the visual attention to the bodies of their patients that students and therapists have displayed in dry-land settings, its absence in the pool was remarkable. This final subsection explores three practices, evidenced by all interaction participants, which suggest that eye-body gaze avoidance is a deliberate pool-based interaction device.

As discussed in Chapter 3, hashed lines on proxemics sketches represent the direction of interaction participants’ gaze. Reviewing the pool-based dataset suggests that therapists in hydrotherapy interactions both avoid looking at the patient’s body part that they are helping to treat and engage patients in direct eye contact. Increased participant eye contact was a consistent observation within the data even, as in the sketches in Figure 7, when the patients could be expected to be quite unsteady and in need of some quick remedial physical help.

Figure 7: Increased eye contact during hydro-based therapeutic interactions.

Figure 7a: Emily nearly in contact with a patient, holding eye contact as the patient goes down a step.

Figure 7b: Louise holding eye contact with a patient on a wobble board.
The change in emphasis of the hydrotherapy interaction to one framed about patient self-exercise meant that the students (who usually only work with one patient in the pool per session) spent periods of time waiting while their patients exercise. The space created provided an opportunity for patients and students to engage in social conversation but also appeared to cause students problems with what to do with their own bodies. While a hydrotherapy pool is warm, standing still in it for any period of time is chilling, and, with much of the pool shallow, standing up in it (when all the patients around you are exercising and thus with their bodies under the water) makes the student very visible – and cold. Two strategies were consistently used by all students to deal with their own bodies in these settings. A common strategy illustrated by Gareth in Figure 8, was for the students to perform exercises that mirrored the patients’. Nowhere on dry land did students engage in a similar activity.

Figure 8: Proxemics sketch recording Gareth mirroring his patient’s exercises.

And secondly, as illustrated in Figure 9, students curled themselves up perching on any available surface, or knelt down (as Gareth in Figure 5b) to keep their shoulders under the water. This body work was quite remarkable and led to frequent incidents similar to that captured in Figure 5b, where a student was on his knees while talking to his PEd.

Figure 9: Students’ body work to keep their bodies under the water.

- Figure 9a: Gareth perched between railings.
- Figure 9b: Louise tying herself in knots to bring her shoulders under the water. Note the increased patient eye contact.
The final interaction practice that drew attention to the absence of eye-body gaze was the 'pool entry / leaving dance'. Implicit in the discussions within this Appendix so far is the recognition that, at some point, the students and PEd have changed out of their uniforms into swimwear, have walked from the changing rooms and climbed a series of steps to get into the pool. An example of the practices by which these dry-land: water-based transitions are managed is captured by the written field note extracts in Figure 10.

Figure 10: Therapists moving between dry-land and water-based interaction environments

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.30 am</td>
<td>We all go down to hydro. Belinda goes into a room and comes back with a clothes hanger with a blue towel dressing gown and black costume hanging from it. As goes into first changing area, shows Gareth the one next door. No sign of Alice.</td>
</tr>
<tr>
<td>12.10 am</td>
<td>Gareth gets out after pt. Leaves Belinda in pool. PTA shows where towels are. Gareth goes to his changing room.</td>
</tr>
<tr>
<td>12.15 am</td>
<td>Belinda and Alice out of pool and discussing where to change. Alice uses small drying room. Belinda goes into changing room and audibly locks door.</td>
</tr>
</tbody>
</table>

The transitions between changing room and pool were excruciatingly painful to observe as, while PEds always came to the pool dressed in NHS navy towelling robes, the students and patients did not. On some occasions students wore towels around their waists or shoulders or otherwise seemed to scurry up the steps into the pool. It was consistently remarkable that the other students, PEd, assistant and I all attended to disattention while this transition phase was in progress.

Appendix summary:

A detailed exploration of the practice of physiotherapy in a water-based setting would fill a thesis in its own right. While no PEd discussed hydrotherapy during our post-observation interview, each student spontaneously offered that they had valued the space both to talk to patients and work out exercises in their own way. John and Gareth, who had misgivings about or misperceived certain aspects of their role and practice in the pool environment, both reported enjoying their time ‘in the water’ and the opportunity to have ‘proper conversations’ with their patients.

The lack of preparation for pool working was noticeable. Perhaps because clinical reasoning and technique development are the clearly articulated goals of the local MSk placement, the PEds do not deconstruct the affordances of the learning environment (positive as well as stress-inducing) in ‘duty’ contexts where clinical reasoning and the implicit value of the work of physiotherapy are rendered invisible. In this Appendix I have drawn out key observations of apparent socialised practices to illustrate the very different interaction practices that occurred during hydrotherapy patient: therapist interactions. Whether the students copied the behaviours of their PEds and fellow students or developed their practice instinctively from their perception of the unique affordances of the pool environment, the consistency of practices observed across the dataset was striking.
Appendix 6: Techniques practice: teaching professional vision and knowing in practice.

Introduction

This Appendix explores students’ opportunities to develop and practise their clinical skills on an MSk placement. Readers will remember that Ian, the lead for MSk placement education at the study site, named skills practice (‘the technical aspect’) as the second main focus of the placements he and his staff created. During my time with the team I observed the following three types of learning environment in which skills learning was the focus: the half-hour twice weekly whole-department themed ‘techniques’ sessions (I observed 5 of these); PEds explicitly teaching students practical skills in a non-patient-related context (I saw one of these); and the daily opportunities for students to plan and practise their skills with each other (again, I observed 5 of these). Analysis of the field notes and proxemics sketches that recorded these learning opportunities suggests that each interaction shared a common purpose that had little to do with skills practice per se. In this Appendix I describe and discuss ‘skills practice’ in the context of Goodwin’s (1994) ideas of learning ‘professional vision’ (p. 606) and ‘embodied professional practice’ (p. 627) and Gherardi’s similar exploration of what she calls ‘knowing in practice’ (Gherardi 2006, p. 14). Framing the observation data within this discussion recognises the underpinning situated learning context of the placement. The discussions will enable me to suggest that ‘techniques practice’ is, in reality, a foil for ‘learning to move, speak, use the instruments and establish the social relations appropriate for the competent reproduction’ of physiotherapy (Gherardi 2006, p. 228), the students’ learning ‘doing being a physiotherapist’ here as it were (after Sacks 1984, p. 417).

Goodwin describes three practices that the archaeology fieldwork educators he observed used to teach their students what he calls the group’s ‘professional vision’ or ‘the socially organised ways of seeing and understanding’ that are distinctive in a ‘particular social group’ (Goodwin 1994, p. 606). The three practices (coding, highlighting, and producing and articulating material representations) were evident in two of the three forms of skills learning I observed and will be explored here.

i. Coding practices in MSk placement education

Goodwin defines ‘coding’ as the practice by which members of a social group transform ‘the world into categories and events that are relevant to the profession’ (p. 608). Using examples that resonate with Lynch and Macbeth’s observation that their primary school science teachers were ‘creating a spectacle of science from the manipulation of everyday objects’ (Lynch and Macbeth 1998, p. 269), Goodwin discusses the creation of archaeology from seams of mud. Coding is thus the way a professional looks at a situation and talks about it in a manner that is both shared by their peers and which makes their professional practice visible.

The ‘techniques sessions’ provide strong evidence of coding practice. ‘Techniques sessions’ were timetabled into each therapist’s diary for two half-hour slots a week. All staff were required to attend except the hand specialist. The ‘technique’ that acted as the focus for each session was agreed in advance by a duty team. All staff within the Department led a session as an opportunity for their own CPD in presentation and teaching. The sessions took place half an hour before lunch in an area of a treatment room that had been screened off to create a long, curtained cubicle. In anticipation of skills practice that always involved paired activity, the cubicle area was enlarged as necessary to ensure that one practice plinth per pair could be accommodated within the space. Technique sessions were the only opportunities students had to come out of ‘their corner’ to mix and learn in the same space as qualified staff. The ‘co-participatory learning’ possible behind the cubicle thus had the
potential to act as powerful situated learning opportunities for the students (Lave and Wenger 1991, p. 14).

On Day 1 of my observation the students and their PEd arrived at the session at 12.40 pm. When we appeared through the curtains we found four plinths already occupied by 4 pairs of therapists. Making another plinth available by changing the arrangement of the curtain, the session leader told the students and their PEd that ‘We are doing impingement tests today. You have missed the talky bit’ before giving them a friendly practical demonstration of the technique the others were already practising. In all instances, the therapist leading the session was the focus of attention.

Figure 1: The proxemics of the ‘talky bit’ of a techniques session.

In Figure 1a the physical focus of the technique on the neck is made clear by the leader’s hands resting on a volunteer’s head and shoulder while she speaks. The model sits still while the leader holds her in this way and talks over her and shares no eye contact with any of the therapists sitting and standing around her. Figure 1b illustrates a similar starting setup but, instead of a pre-prepared model, the therapist is holding down a piece of paper with her knee on a stool. This piece of paper and the inanimate model were the two notable artefacts in all techniques sessions and provide the visual evidence for the discursive coding practices that I now explore. Figure 2 presents a field note extract of the verbal element of a techniques session introduction.

Figure 2: The verbal elements of the ‘talky bit’.

Day 6: Belinda leading session

Belinda: ‘So today we are going to look at dynamic control to build support but to see too if we can reproduce their pain. The first thing you need to do is to load the area. What they say you are looking at is …. So you need to communicate that to them. So can I have a model please?’

The short verbal extract in Figure 2 captures the consistent first few minutes of each techniques session and illustrates coding in practice. It is important to note that the extract is taken from my final day in the field when I was making a specific attempt to capture this interaction as accurately as possible. Each introduction was very quick, difficult to record and code-laden but did important work to set up what followed as acceptable and expected physiotherapy practice. In Figure 2 Lines 2-3 for example, Belinda uses the phrases ‘dynamic control’ and ‘load the area’ to create the spectacle of physiotherapy from what we shall see later is asking a patient to lift up one leg while they lie down. It is notable too that Belinda’s use of the expressions ‘their pain’ and ‘communicate that to them’ (Lines 3 and 4) appear to be understood by the group as reference to the otherwise absent patient. Both the
use of physiotherapy language and the hidden meaning of seemingly commonplace expressions illustrate what Garfinkel and Sacks (1970) describe as Belinda’s ‘mastery of natural language’ (p. 342). Garfinkel and Sacks (1970) define natural language as the shared understandings that are conveyed to social group insiders in ‘just so many words’ (p. 342). Thus while Belinda, in Figure 2 Lines 3 and 4 appears to be using everyday language in abnormal ways, the meaning of her words is recognised by those present and, as illustrated in their later actions, understood in the way she intended the words to be heard.

Figure 2 illustrates two further coding practices. In the short phrase ‘What they say you are looking at’ (Lines 3 and 4) Belinda is signalling to the group that what she is teaching has been sourced from some external other and is grounded in a body of respected literature i.e. not something she has made up herself. Finally in Line 4 Belinda asks for a model with the expectation that one of her peers will step forward and volunteer. I think the role of the model is crucial both to the work being done here and the endorsement of physiotherapists’ expectations of their patients during therapeutic interactions and is thus discussed further below.

Figure 3 records the student Emily being trained in model-appropriate behaviour. The sketches were taken on the second day of my fieldwork with the MSk team in a session that was the only time I saw a PEd explicitly lead a skills development session for her students. The interaction was requested by Diane (Emily’s student-peer) to help her prepare for an ankle assessment that she would be performing the following day. At the time of the sketches and verbal dialogue in Figure 3, Amy the PEd had already ‘gone through’ the standing assessment with Emily while Diane modelled. Figure 3 records the proxemics and verbal elements of Diane’s teaching while Emily ‘models’.

Figure 3: Learning appropriate model behaviour.

Figure 3a: Amy (PEd on right) demonstrates to Diane. The ‘model’ Emily is looking up and down and she tries to follow what is being said.

Figure 3b: Diane palpates Emily’s feet under the watchful eyes of Amy. Emily looks ahead and ignores them.
Figure 3c: Diane and Amy sit back, cross-legged and discuss Emily’s feet. Emily continues to ignore them.

1 2.47 pm students swap over;
2 Amy to Diane: ‘So observe from the front... Just stand tall.’ (Figure 3a)
3 Diane: ‘So when they have x here, they have…?’
4 Amy: ‘Yes sometimes...’ expands ++
5 Amy to Emily: ‘Just rock back and forwards.’
6 Emily rocks, middle distance gaze, Diane and Amy scrutinize her feet (Figure 3b)
7 Having palpated D and A sit back and discuss. Emily effectively absent (Figure 3c)
8 2.50 pm
9 Amy to Diane: ‘So still in standing you need to... one leg stand?’
10 No looking at Emily, Emily continues staring at wall and stands on one leg;
11 Amy points things out... Emily must hear but ignores
12 Diane: ‘What is that called?’
13 Amy: ‘Ligament laxity tests....’
14 Amy demos on Emily
15 Amy to Diane: ‘Would you like to have a go?’
16 Diane tries several different ways
17 Amy: ‘You will find the way that is best for you.’
18 Emily: ‘Oh that is better.’
19 No time to swap over as Diane’s next patient is in.

Figure 3a captures Emily trying to observe what Amy and Diane are doing to her feet. Looking at her feet causes Emily to wobble backwards and forwards which alters what her feet are doing to balance her. To assess the way a foot supports a patient in standing, the body on top of the foot should be as still as possible. In Figure 3 Line 2 Amy’s ‘Just stand tall’ is directed at Emily. While no eye contact is made, it is clear from Emily’s immediate adoption of her posture in Figure 3b that she has understood the instruction to be aimed at her and to require her to stand still and let the therapists at her feet get on with their work. The importance of the model in co-constructing the physiotherapist’s work is evidenced in Lines 5 and 9 as Emily responds to Amy’s later commands without comment. I think the data in Figure 3 evidence a PEd teaching ankle assessment but also, implicitly, teaching students how to train their patients to act as competent models that release their physical data on command (see Chapter 5 Figure 5.13).

Having explored the role of the model in the teaching session, I return to our discussion about the students’ development of professional vision and the practice of coding in
particular. Figure 3 Lines 3-12 record Diane and Amy moving between periods of observation, palpation and discussion as they focus on what they can learn about Emily from her feet. This cyclical progression of talk and action supports Gherardi’s observation that learning and knowing in professional practice are not separate activities ‘but instead take place in the flow of experience with or without [the students] being aware of it’ (Gherardi 2006, p. 14). In her choice of words to both students we can hear Amy using the language of physiotherapy (the code) to teach them observation, thinking and patient management skills. In her physical actions we see her performing Goodwin’s second teaching practice: highlighting.

ii. Cycles of coding and highlighting to create physiotherapy work

Goodwin describes ‘highlighting’ as the practice by which a teacher marks out in some way the focus of the professional’s work from the noise of co-existing features of the environment. As illustrated in Figures 3a and 3b, a crucial part of therapists’ work is the observation and palpation of exposed body parts. But, as illustrated in the text in Figure 3, students need to be taught what to imagine they are seeing and feeling from those bodies and use the language of physiotherapy to describe it. A central feature of all techniques sessions was thus the constant interplay between verbal and visual stimuli. Figure 4 records this interplay during the demonstration phase of a techniques session led by Naomi.

Figure 4: Coding and highlighting in action.

Day 5 12.40 pm
1 Naomi: ‘Can I have a model please?’
2 Flora (Band 7) volunteers
3 Naomi rolls up Flora’s top, Flora stands facing the wall to expose her back to her peers.
4 Naomi: ‘So up and onto PSIS. Can I just pull your trousers down a bit?’ Does to expose top of buttocks. No response from Flora who stands facing wall (Sketch below).
5 Naomi: ‘So the second part is looking at what the other leg is doing. Hang on I need to check this’ (walks to her notes) reads: ‘So, hold, rotate, stabilize onto sacrum.’ (Sketch below:
6 Naomi speaks the steps as she physically demonstrates)
Naomi performs activity (sketch above) in silence
Naomi stops: ‘Does that make sense?’
Nods all round.
Naomi: ‘OK go away and practise.’

Figure 4 is typical of the demonstration phase of a techniques session. Each model competently performed their role as inanimate body and, as illustrated in Lines 4 and 5, made no verbal or physical response to the session leader’s seemingly rhetorical questions to adjust clothing. In each session I observed, models waited for therapists to adjust clothing for them. As the demonstration progressed all session leaders (whatever their grade and seniority) appeared to authenticate the practices they were teaching by using physiotherapy language to describe the body parts they were working on (Line 4 Figure 4) and alluding to knowledge they had acquired elsewhere. Typically the session leader was challenged to evidence this authenticity specifically. The session leaders appeared to use coded language and references to a greater knowledge even more explicitly when they were challenged by their peers in this way.

Figure 5: Responding to challenge by further coding and highlighting.

Day 1: 12.47 pm
Physio to session leader: ‘What is that anatomically? Where did you get that from?’
Session leader: ‘I’m not sure. I suppose… not sure of the evidence as it were, but I shall show you anyway. Apparently it…..’

Session leader refers to notes, puts them back under her model’s thigh so she can still see:
‘So as it says in the book….generally how they say to do this is…’
The snippets of field work data presented here illustrate how the MSk team at the study site use the techniques sessions to affirm the nature and language of their work through a process of shared observation and dialogue. While coding and highlighting the work of physiotherapy has been evidenced, it is the shared articulation of practice philosophies and expectations that is the primary purpose of the ‘Techniques sessions’. I use data from the ‘practising’ phase of the sessions to explore these ideas further below.

iii. Talking and feeling: producing and articulating representations

The command to ‘go away and practise’ (as in Figure 4 Line 13) is the signal for the therapists in a techniques session to pair up and move to a plinth to practise the skill they have just had demonstrated. If the participants’ intention was skills practice, one might expect repetition of that skill. During a techniques session however, once at their plinth, therapists appropriately exposed the relevant body part of the partner who had agreed to be ‘model first’, and then, by linking informally with peers on adjoining plinths began cycles of observation discussion and palpation without actually performing the skill requested. Figure 6 offers an example of this peer-assisted interaction.

Figure 6: Collective observation, palpation and discussion.

In Figure 6 one therapist palpates the model’s back while another closely watches. The pair behind the model discuss what they are seeing, and one is feeling while the model stands motionless. After about 5 minutes the session leaders will try to draw participants back to a central area to teach another related skill using the phrase ‘OK two minutes and we will come back.’ At this point participants consistently return to their plinths, and seemingly in a hurry, perform the previous skill a couple of times only. It is common for the group to move to the next demonstration phase before models have swapped and all therapists thus practised.

The lack of actual skill practising was a consistent feature of techniques sessions. One possible consequence of the lack of attention to the skill, and specifically an individual’s application of that skill on a range of different bodies, is that potential risk to therapists and patients of poorly performed skills were overlooked. Figure 7 records the application of a skill
by both a student (Figure 7a) and an experienced therapist (Figure 7b). While the student and therapist may be performing the same physical handhold to apply their body force to effect change in the patient, the pressure on the student’s lower back is likely to be substantial. There are many similar sketches and field note extracts in my data that illustrate the focus of skills teaching on the handhold area only (see for example Figure 4 Line 8) and poor performance of uncorrected skills (Figure 7a).

Figure 7: Comparing student and expert skill performance.

The reality of the interactions I observed during the practice phase of the technique and PEd-led skills sessions suggests that developing skill performance competency is not the real learning taking place in these settings. Instead the sessions are opportunities for qualified therapists to share ‘discursive practices that … create the objects of knowledge that become the insignia of [the] profession’s craft’ (Goodwin 1994, p. 606). Through their actions, words and non-actions, the qualified staff are reinforcing their identity as a profession able to create their work from the human body. The data presented here suggest that the human body (not a patient within that body) is the ‘locus of [physiotherapy’s] embodied practice’ (p. 627), the vehicle through which their work is effected.

Close study of the students’ interactions during the practice phase of skills sessions suggests that their learning needs are more complex than those of the qualified staff. As illustrated in Figure 3, students spend time looking at and feeling body parts while talking through what it is they are seeing, feeling and thinking with their PEd. Rose described the main challenge for students learning physiotherapy skills in university classrooms as being ‘the push toward articulation of the tactile’ (Rose 1999, p. 149). The data in this Appendix support Rose’s suggestion that the interplay between hand and mind as the students feel a body is the ‘mechanism by which their hands come to know and they make a particular kind of sense out of what they feel’ (p. 147). My data also suggest that students, if left to their own devices, are not able to perform this interplay between hand and mind effectively, and, as a consequence, cannot fulfil their PEds’ expectations to use their daily ‘skills practice’ session as qualified staff might do. Figure 8 presents four mini sketches of the students’ activities during their daily 8.30-9.30 am slot. Alice and Gareth’s short episode of peer-assisted discussion of an ankle assessment in Figures 8a and b were unusual in my data set. Figures 8c and d reflect the much more common lone student preparation activities.
Figure 8: Typical student morning activities.

Figure 8a: Alice (on the left) palpating Gareth’s bare foot.
Figure 8b: Gareth reading aloud while Alice palpates his foot.

Figure 8c: Emily palpating herself while reading.
Figure 8d: Individual study time.

Only on one occasion did I observe a skills practice session led by students for each other (Figure 9). To draw this Appendix to a close I discuss this interaction as an example of an activity that seems to be too challenging for students to undertake without the support of their PEd. The day before the interaction recorded in Figure 9 Caroline had taught Louise some hip tests while John had been assessing a new patient. Caroline asked Louise to teach John the exercises in their ‘morning skills session’. Figure 9 observes this interaction.
Day 6 8.43 am
1 Louise: ‘I need some water and then I need to do the session from yesterday’
2 Louise back, John acts as model and lies on the plinth;
3 Louise: ‘She… and then bend in and get them to …., then you’d….’
4 Louise performs three skills once each;
5 John: ‘So would you support… so would you do that for the patient first or get them to do it?’
6 (Sketch below Louise teaching John. Note her very passive stance, she is literally moving
7 one hand, her posture is loose and static.)

8 CK reminds Louise about what else she learnt with Caroline.
9 Louise teaches one more skill;
10 8.47 am students change over
11 John: ‘So I…’
12 Louise: ‘Yes but perhaps put your hand here.’
13 John: ‘So I hold here and move you…?’ (Sketch below)
14 Louise: ‘No to do that you put your hand there.’

15 John: ‘Cool’.
With the exception of the patient-absent language Louise uses in Figure 9 Line 3, there is little else that is similar between this student-only skills session and the other skills teaching data I recorded. In the first sketch of Figure 9 Louise appears to have little energy for the teaching task as she stands at the end of the plinth and seems to be making John perform the test himself. Despite John’s efforts to question Louise and practise on her (Lines 10-14), John quickly gives up and five minutes after they started peer-learning the pair resume their individual study. Looking at the data in Figure 9 in the context of our discussions about the implicit purpose of the techniques sessions, suggests that the MSk PEds are asking too much of their students to practise unsupported. Gherardi describes professional learning in terms of a ‘knowing in practice’ that is ‘as an accomplishment realised by establishing connections in actions’ (Gherardi 2006, p. 229). From her perspective of learning in situated learning environments, Gherardi suggests that the role of the professional educator is to help students recognise and then establish connections between their knowledge and practice. As Sacks notes, if it is everybody's business in a social group is to be ‘occupationally ordinary’, then students in that social group must not only know what ‘everybody is doing ordinarily’ but ‘have that available to do’ (Sacks 1984, p. 415). The data in Figure 9 illustrate novice practitioners who cannot perform competently because they do not yet have the internal frameworks in which to integrate their thinking, speaking, feeling and seeing.

Appendix Summary:

Skills practice and development are core learning opportunities built into the MSk placements offered at the study site. The electronic diaries reflect this emphasis and the value the local unit places on explicit skills development for its staff. As one of the few occasions students have to see and work in the same space as their qualified peers, the twice weekly techniques sessions afford powerful socialisation opportunities. This Appendix has explored the environment and practical accomplishment of students’ skill development opportunities and suggested that the affordances are not for learning skills per se, but rather for learning the professional vision of their social group. Through the words and actions of the therapists and students we have seen how techniques sessions provide a situated learning environment for the continuation of physiotherapy practice that values science-based knowledge and creates their professional work through the objectification of the human body. The field note extract in Figure 10 suggests that the very last thing that seems to be in anyone’s mind during a skills practice session is skills practice.

Figure 10: Social group affirmation confirmed, so no need to practise the skills.

| Day 2 12.57 pm |
| Leader, notes under model's hip: ‘Right the last one is Lat Dorsi…..’ |
| Shows gross movement on model |
| Leader: ‘Anyone want to practise?’…. nothing back… ‘Any questions about that?’ |
| Band 6: ‘Not really we want some lunch.’ |
| Leader: ‘OK, we’re ready for lunch. Thank you.’ |
| All: ‘Thank you’. |
| Open curtains, all leave. |