This is a book for practitioners working in community-based healthcare as well as educators of future practitioners and researchers exploring this practice field and for people with chronic disabilities and their families and carers. The book invites readers to re-think and re-shape the way that community-based healthcare is practised by practitioners and experienced/engaged with by clients/patients and their families and other carers.

Based on a PhD study of therapeutic relationships in community healthcare settings in NSW, Australia, and on real-life experiences of practitioners, clients and clients' families and care givers, this book paints a rich picture of the lived experiences of these participants in community-based healthcare. It examines the issues and challenges they face and the ways they deal with these.

Key themes identified across the book are: the value and nature of relationships in this unique healthcare setting, the importance of time and using it well, the way good teamwork facilitates good community-based, patient-centred healthcare, balancing autonomy and equality with healthcare quality, practice wisdom embodied in healthcare, and ways of improving healthcare in clients' own homes.
Community-Based Healthcare
Community-Based Healthcare

The Search for Mindful Dialogues

Edited by

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**Contributors**
This series examines research, theory and practice in the context of university education, professional practice, work and society. The series explores spaces where two or more of these arenas come together. Themes that are explored in the series include: university education of professions, society expectations of professional practice, professional practice workplaces and strategies for investigating each of these areas. There are many challenges facing researchers, educators, practitioners and students in today’s practice worlds. The authors in this series bring a wealth of practice wisdom and experience to examine these issues, share their practice knowledge, report research into strategies that address these challenges, share approaches to working and learning and raise yet more questions. The conversations conducted in the series will contribute to expanding the discourse around the way people encounter and experience practice, education, work and society.

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This is a book for practitioners working in community-based healthcare as well as educators of future practitioners and researchers exploring this practice field and for people with chronic disabilities and their families and carers. The book invites readers to re-think and re-shape the way that community-based healthcare is practised by practitioners and experienced/engaged with by clients/patients and their families and other carers. Healthcare occurs within systems and in this case we are talking about the system of community-based healthcare which provides long-term care and support for people with chronic disabilities, and for their families and other carers who participate in the healthcare and support of their family members, friends or clients. The ethos and goals of these systems make a significant difference to the lives of these people. All who are involved in this system (from funders to healthcare providers to support people to clients/patients) need to recognise that both the way the system is constructed and operates as well as the principles and practices it espouses and enacts, are critical to this healthcare; to the experiences, wellbeing and successful care of the clients whose lives can be enhanced or limited by the nature and quality of the care and support they receive and by the role they also play in this process.

This book has left far behind the concept of healthcare as a biomedically-focussed practice with its restitution narrative and it moves beyond a wellness model and narrative with practitioners taking the role of providers of healthcare. Instead, the research underpinning the core healthcare model presented in the book epitomises an approach to healthcare that the authors consider essential to people who have chronic disabilities, have the desire and capability to write their own life and wellbeing narratives, wish to be co-creators (not just recipients) of their healthcare strategies, are often the owners or inhabitants of the places where their healthcare is conducted and who know more about the realities of their health aspirations and situation than anyone else.

The ideas and research presented in this book are built on an emerging body of work that has identified the importance of context for the practice of home-based healthcare and the need to expand our ideas of knowledge and practice, “beyond the basics” (Heckman & Cott, 2005, p. 280) within this field. Research by Iversen et al. (2008) has highlighted the importance of shared, effortless dialogue and meaning construction and co-construction for therapeutic interaction and Øien et al.’s (2010) research identified the necessity for therapists to be sensitive to and negotiate difficult and dynamic situations to create change and new ways of therapists and patients interacting with each other.

The book has four sections: setting the scene of community-based healthcare, presenting the central research project for the book, lived experiences of participants in community-based healthcare, and ideas about ways forward in this healthcare arena. Authors include the researchers, clients and carers (including a number of participants in the research project) and other workers in this field.

The central research project presented in Section 2 of the book, reveals an embodied style of practitioner-client relationship development perhaps only
possible in people’s homes where the special, local context strongly influences every aspect of the relationship being developed between clients, families and carers. The aspect of private practice within the study added a further dimension that affected relationship development. In the research, six client voices, Eric, Jenny, Jack, Dennis, Adam and Erin (pseudonyms) and their community-based physiotherapists (Karen, John, Lynne and Barbara (pseudonyms) speak out strongly in conversation with Diane (Tasker) the principal researcher. Each of these participants brought their long-term experience (as people with disabilities, family members, carers and as practitioners) to enrich our understanding of this complex, challenging and rewarding field of practice.

In Section 3, narrative chapters have been written in company with a wide range of practitioners and stakeholders. These stories from practice from the perspectives of different practitioners and stakeholders in community-based healthcare are lightly inspired by Geoffrey Chaucer’s late 14th century Canterbury Tales, where a traveller talks to other travellers to hear their tales and better understand them. The intent of writing these chapters in company with practitioners from many different disciplines and levels of experience can be seen as phenomenological in nature - like the Mindful Dialogues study itself, where the interviewer wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of conversation as “wandering together with” (Kvale, 1996, p. 4). The chapters in Section 3 also encourage dialogue between the authors to explore what they consider to be important issues in community-based healthcare and the relationships that develop therein.

In Section 4, authors have contributed discussion and application of central themes and ideas to the field of community-based healthcare in an effort to think forward for and with the people involved in community-based healthcare. The authors involved have long experience as both practitioners and academics; their visioning and thinking can assist development of practice in this field.

We invite readers to reflect on their practice, their lives, and their current and possible ways of being, knowing, doing and becoming in this space of living, practising and co-creating life possibilities. This is a book to dip and delve into; to read and reflect upon. We encourage you to make time for thought and goodwill in your busy lives and engage in dialogue with others.

Diane Tasker, Joy Higgs and Stephen Loftus

REFERENCES


SECTION 1

SETTING THE SCENE:
COMMUNITY-BASED
HEALTHCARE
1. COMMUNITY-BASED HEALTHCARE

In recent years community-based healthcare has started becoming more important. This is because hospital stays are becoming much shorter. Clients are being discharged from hospital into community care much earlier than they were in the recent past. As our ability to deal with acute conditions, such as the trauma from road accidents improves, more people are surviving with impairments which need continuing care, usually provided in the community. In addition to this, an aging population means there has been a steady rise for some years in the number of people with chronic conditions who live in the community and are cared for in that same community (commonly referred to as “aging in place”). As the baby boomer generation moves into old age, the number of older people being cared for in their community is expected to rise dramatically. There is a pressing need to have a better understanding of community-based healthcare in its full complexity. In this chapter we draw attention to some of the factors that contribute towards that complexity and how health professionals can engage more fully with community-based healthcare.

Conventional ways of viewing healthcare leave much to be desired as they are dominated by the discursive lenses of managerialism and competency-based practice. These discourses have a limited vision and vocabulary. If we rely exclusively on these approaches then much of the complexity of community-based healthcare will go unnoticed and be poorly understood. Managerialism and competency-based healthcare have a focus on the short term and the superficial. This is seen in simplistic attempts to “deliver” so-called “packages of care” quickly and efficiently and at the lowest cost. There is an underlying assumption that healthcare can be packaged up and so delivered. While this may often be true in the acute setting, long-term community care needs a different kind of thinking and relies on different assumptions. Relationships develop between health professionals and clients (and their families) where long-term care is provided in the home on a regular basis. Acute care thinking sheds no light on the nuances and subtleties of the relationships that develop in more long-term community-based care. We argue that ideas from such disciplines as narrative medicine, neo-Aristotelianism and dialogism are particularly useful in helping us understand the complexity of community-based healthcare. If we are to provide this care in a manner that truly helps people (and is effective and efficient at the same time) then we need to engage with this complexity.
Recent research has started to open up the complexity of community-based care settings (Tasker, 2013). A clinical encounter in these settings is often one in a long series of encounters that can go on for months or even years. This means that there is time for the participants to get to know each other well and develop complex relationships that evolve over time. The relationships are not only between the health professional (e.g. a physiotherapist) and the client (sometimes called client) but also between the health professional and the families who provide the ongoing care when the health professional is not physically present. Health professionals, therefore, need to be sensitive to how such relationships can develop and do what they can to ensure that these relationships remain healthy in order to provide a setting where all concerned can benefit. Health professionals must, therefore, find a balance between being friendly and supportive on one hand and maintaining a professional distance on the other where they can fully exercise their specialised skills and knowledge. Most health professionals tend to learn their specialised skills and knowledge in clinics and acute hospital settings, which are designed so that health professionals can be as efficient and effective as possible. In these settings, initiative and power rest with the health professionals who are in familiar surroundings with all the paraphernalia that goes along with their profession. In community settings clinical encounters often take place in a client’s home where clients and families are on familiar territory where they can take some initiative and can expect some power sharing. All this can affect how professional relationships develop. In hospitals, health professionals hold nearly all the power. In people’s homes the balance of power is a little more even.

One common example is that of a physiotherapist who makes visits to a client in their own home. It has been pointed out that in these settings the physiotherapist is entering a “sacred space” (Tasker, 2013, p. 170) when therapy moves into the family’s space. Health professionals need to be very mindful of this dynamic if they are to be able to respect people’s rights to privacy and autonomy within their own home and this dynamic extends to respecting the body of the client as well. Clients and families usually want to decide what is important to them as a family as well as what is important to the person directly receiving the healthcare. Health professionals and support workers from different disciplines are also involved and so the breadth and complexity of healthcare support in the community builds. There are a number of theoretical frameworks that can be used to help us conceptualise such complexity and we discuss some of these next.

**DIALOGISM**

One theory that has much potential to help us understand the complexity of community-based healthcare is dialogism. This is based largely upon the work of the Russian scholar, Mikhail Bakhtin (1981, 1986, 1984, 1990), whose work has started to influence many disciplines since it came to the attention of the western world towards the end of the twentieth century. In dialogism, dialogue provides a
metaphor for comprehending meaning. In dialogism it is assumed that all meaning arises from relationships, whether this is someone reading a text, or two people in conversation within a clinical encounter. There is no inherent meaning in the text or in the individuals but meaning arises when these entities relate to each other. Hence, my reading of a text will necessarily generate different meanings from your reading of the same text because we come from different backgrounds and establish different relationships with that text. The same applies to human relationships. The implication for healthcare is that every clinical encounter is necessarily different from every other even though they may follow much the same pattern. There will be subtle differences between the meanings generated with one physiotherapist and a client compared to the meanings generated with another physiotherapist even though they may be trying to deliver the same therapy to the same client.

In a study of physiotherapeutic relationships in community-based healthcare (Tasker, 2013), the family of “Jack” (not his real name), a young man with acquired brain injury told of the way he and the family related to his therapist at home compared to the therapist who had helped him in the hospital prior to his return home. While the context within which those therapies had taken place had obviously affected the way this young client perceived and responded to his therapy, the different people involved also affected his reaction to the different therapists and the meaning he gained from their interaction together. His father told of the development of this home-based therapeutic relationship where he had gradually gained insight into his son’s need to be independent in his own way after listening to the quite experienced community physiotherapist as she worked with Jack and all the family in their home. The aims of the basic physical therapy being conducted in hospital and at home may have been quite similar but the way the therapeutic relationship between these people played out had particular and different meanings for Jack and his family. We need to be keenly sensitive to such subtle differences in meaning if we are to be able to connect with our clients in ways which can help them.

Another aspect of dialogism is the acceptance of multiple voices and the autonomy of those involved in relationships. Bakhtin pointed out that the novelist, Dostoyevsky, took pains to avoid a god-like relationship with the characters in his novels. It was as if Dostoyevsky gave his characters the autonomy to be themselves. How does this apply to healthcare? The traditional view of the clinical encounter is that the health professional’s voice is dominant and is the only voice with any power. Clients and their families are traditionally expected to do what they are told. In a more dialogical approach it is accepted that all participants have a voice and a viewpoint that needs to be taken into account, even though the health professional is recognised as having specialised knowledge and expertise. Therapeutic plans need to be negotiated with clients and families in a manner that allows everyone concerned to feel they have made a valid contribution and have been heard. There is dialogue of all participants rather a monologue from the health professional. A dialogical approach also allows the voices of other disciplines to
inform what we can understand of the clinical encounter. One other such discipline is narrative inquiry.

NARRATIVE

The study of narrative encourages us to pay attention to the ongoing stories that clients and their families are living out. The community-based healthcare needs to become part of the client’s narrative and all concerned need to be involved in this. Mattingly (1994) showed the usefulness of adopting a narrative approach to rehabilitation therapy. In her case, the clients were young men permanently disabled by trauma, frequently motorbike accidents, who were having to make adjustments to a new life living with impairment. The exercises and routines were presented as part of the new life story that the clients were invited to develop for themselves. The narrative approach gave meaning and direction to the therapy provided. The new life story of a fulfilling life that included coping with impairment was seen as the overall goal of therapy. With a meaningful goal, there was incentive to learn how to overcome and cope with a disability and move on with life, even if that life now had to be radically different.

In community-based healthcare there is the same need for narrative sensitivity. Many of these clients may be entering their final years and are expected to decline. Their narrative possibilities may be limited but they are still living out their life stories and therapists need to be sensitive to these stories and the role community-based healthcare can play within them. To add to the complexity there is a need to be sensitive to the ways in which the life stories of clients may be interacting with the life stories of the family members who do the caring.

Recognition and understanding of what people are trying to communicate about the meanings in their relationships with their health professionals was facilitated in a research study through the use of such skills as poetic recognition of the language and phrases used by clients (Tasker, Loftus, & Higgs, 2014). This has implications for professional practice as well. Such sensitivity on the part of a healthcare professional can also be described in terms of phronesis.

PHRONESIS

Phronesis has been described as practical wisdom or the disposition to act wisely (Aristotle, 2012). It comes from neo-Aristotelianism where it is contrasted with episteme, propositional knowledge, or knowing that, and techne, technical procedural knowledge or knowing how. Phronesis is the ability to deal with the uncertainty, complexity, value conflicts and uniqueness of practice situations. Community-based healthcare is often full of such situations. Practitioners who are going to become involved in these settings need to develop a deep sense of phronesis and accept that the complex relationships and demands made upon them mean they will need to accept complexity and uncertainty as part and parcel of community-based healthcare.
Situational complexity can involve potential value conflicts, such as finding a balance between providing high quality care and cost-effective care. The complexity may involve helping clients and family members to negotiate life stories that are mutually acceptable. For example, clients may worry about being a burden to their families and resist home care while those same families may want home care provided. Conversely, while some clients may want to live out their days at home, and die surrounded by family in familiar surroundings, family members may feel that home care is too much of a burden and be overwhelmed with the responsibility and the adjustments needed in their own lives. There is no single right way that can be imposed on everyone involved. Every case will be different and needs to be managed carefully. Health professionals may need to help clients and family members to articulate their desires and expectations so that there is the possibility that meaningful life stories can be negotiated for all concerned. All this means that practitioners need to be able to engage in reflective practice, both reflection-in-action and reflection-on-action (Schön, 1983, 1987). Reflective practice opens up the possibility of developing practice wisdom.

Practice wisdom depends on the abilities of practitioners to reflect upon and learn from their experiences. The experiences, where complexities such as value conflicts or ambiguity can prevent decisions and management from being straightforward, are the very experiences that demand reflection. Practitioners can find themselves asking difficult questions that have no easy answers. What exactly is going on here? What options are possible? How does my behaviour/relationship need to be modified in order to bring about the best possible outcome for everyone? What compromises have to be made and who is going to make them? Whose interests are being served by each decision option? What is the ethical thing to do here? Do I need to bring in someone else? In order to answer these questions practitioners need to develop the phronesis mentioned earlier, the disposition to act wisely. This phronesis cannot be taught but junior practitioners can be given the chance to develop it by working in practice settings where they have the chance to encounter some of the difficulties mentioned. They also need to work with more experienced practitioners who can role model how to cope with complexity and who can mentor the juniors as they jointly reflect on the problems thrown up in practice and how to cope with them (see chapter on Mindful practice in Section 4). This practice-based approach to education fosters the development of what has been called praxis.

Praxis has been defined as morally informed and morally committed action (Kemmis & Smith, 2008). It is a form of practice that is deeply ethical where there is a conscious effort to bring about the best outcome for all concerned, especially clients, recognising that the best outcome can vary depending on subtle changes in context. An example of such praxis can be seen in community health situations where considerations of safety must be weighed with “dignity of risk”, especially for people with cognitive impairment, who are living alone in the community and who wish to remain doing so. Advocacy for these people must be tempered with both communication and education of those around them and careful ongoing interaction if the needs, wishes and fears of all concerned are to be fully taken into
account and the client to be safe in what they wish to do. Indeed, the health professional’s access to the situation may well also depend on the ability to adequately manage such complex situations. The Mindful Dialogues model (Tasker, 2013) of being mindful, staying engaged and being responsive is of utmost importance in such professional praxis (see Section 2).

CONCLUSION

It is clear that community-based healthcare can be extremely complex in ways not seen in acute care settings. There are nuances and subtleties that are simply not present in clinics and hospitals where most clinicians learn their professions. While clinics and hospitals have their own complexities the nature of these can be quite different. Therefore, those who engage in community-based healthcare need to be made aware of the particular complexities they face and be prepared to engage with them. The rest of this book explores some of these complexities in more detail.

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SECTION 2

A QUALITATIVE STUDY INTO COMMUNITY-BASED THERAPEUTIC RELATIONSHIPS
2. CONSTRUCTING MINDFUL DIALOGUES IN HEALTHCARE

A Phenomenological Study

The curiosity that inspires qualitative research often comes initially from observations of the real world, emerging from the interplay of direct experience with emerging theory, of political commitment with practice, as well as from growing scholarly interests. (Marshall & Rossman, 1999, p. 25)

THE ORIGINS OF THIS RESEARCH

This research arose from four key points of reflections and concerns:

- the imbalance between the need for community-based healthcare in the context of aging populations and the limited attention given to such programs in healthcare systems
- the concern that a different approach was needed for chronic healthcare in which different practitioner-client relationships were essential
- the need for greater recognition of the role of clients and families in community-based healthcare, particularly where their homes become the venue for healthcare
- the experience of the principal researcher (Tasker) in addressing these concerns.

Community-Based Healthcare and the Need for Better Attention

Throughout the ages, people have always been cared for at home when they have become ill or disabled. However, in Western society, the introduction of hospitals and the hegemony of specialist medical practices over the last century may have affected the place of community-based healthcare within healthcare systems. The development of community-based healthcare as an add-on to hospital-based healthcare (Lechner & Neal, 1999) may have occurred as a result of a lack of interest in chronic and complex healthcare by specialists who have historically focused on acute conditions, where there is a greater possibility of substantive cure (Bishop & Scudder, 1990).

However, as the economic burden of healthcare for our increasingly aging population becomes more pressing, public interest has again turned to community-
based options. Such options can save money but also have the potential to promote an enhanced quality of life for individuals with chronic health conditions, providing home-based care to transition clients into improved health, rehabilitation, or as ways of coping with chronic conditions.

Finding a Different Approach to Community-Based Healthcare

Assisting people with healthcare needs who wish to remain in their own homes is a desirable outcome for many people. As our society ages, discourse regarding the care of people with disability becomes more important and more urgent. It is dominated by concern from community members regarding the quality of care achievable by healthcare organisations, for example, hospitals and nursing homes. Increased understanding of the therapeutic support required in community-based healthcare settings may contribute some resolution to the increasing problems of our aging society and its healthcare needs. In community-based physiotherapy, such therapeutic support can be centred within the relationships, which develop between physiotherapists, clients, families and carers.

Recognising Client and Family Needs and Roles in Community-Based Healthcare

In informal discussions with colleagues from general medical practice and other healthcare professions regarding this research, wholehearted belief was expressed that community-based healthcare essentially depends on therapeutic relationships with clients, their families and carers. In a world that values accountability for economic reasons as well as desirable healthcare outcomes, this project tried to illuminate the human relationships experienced by community-based therapists and their clients.

This research contributes deeper understanding and new meaning to the discourse regarding the provision of customised therapeutic support for people living at home with chronic and complex healthcare needs. Within this study, the contributions from all the stakeholder participants in community-based physiotherapy situations demonstrates the way that all people within such situations contribute to person-centred healthcare processes.

Being a Different Kind of Community Health Carer

Professional healthcare practice is not only about “doing” but also about “being” and the formation of one’s professional persona is a delicate balancing act for all healthcare professionals. Through her 25 years of community-based physiotherapy practice of the principal researcher, first author, Diane became increasingly aware of the complexity and fragility of the human relationships, which develop between physiotherapists, clients, their families and carers. She noted particularly that a deeper, unhurried and more socially sensitive, interactive approach supported the development of wellness for her clients and their families and sustained her energy as a therapist and as a person. She recalls one client for whom it was her emotional
support for the person, not any physical therapy that made an enormous difference to a physical state that had become a disability for over two years.

As a physiotherapist, I often wonder just how much I have contributed to a client’s progress. Is it what I did or how I did it, or what they thought and did, or something in the interaction between us? There are times in clinical practice when I have to stop and really question myself about this. Some time ago, I visited an elderly man with back and hip pain. He was bent right over. His doctor told me that this flexed body posture has been present for at least 2 years that he could recall. This client also had very poor vision. He had quite a prickly personality but gradually our conversation progressed.

I asked him about his life in general and he told me with some distress that he couldn’t believe that this had happened to him, and that in his youth, he had been a very good athlete. He got out a photo album and showed me a picture of himself as a teenager. I admired his beautiful upright posture in the photos and asked him if he could remember what that had felt like. We chatted about how he managed his mobility and arranged some appointments and a plan of action. I also assessed him physically and suggested that he use his walking frame in the house instead of just on outings.

Imagine my surprise when I visited the next week. He greeted me at the door with a big smile, standing nearly upright without his walker. To say that I was surprised is an understatement. What I was sure of was that it was not any evidence-based physiotherapy procedures that had wrought this change.

Diane became increasingly fascinated by the role and importance that such human relationships could play within clinical practice and how attention to interpersonal interaction could help clients, families and practitioners in their effort to achieve wellness and good health outcomes. This interest led her to enrol in a doctoral program to research the community-based physiotherapy relationships that develop between community-based physiotherapists, their clients, clients’ families and clients’ carers.

THE CONTEXT OF THE RESEARCH: COMMUNITY-BASED PHYSIOTHERAPY

Although physiotherapy as a profession was established only within the last 100 years, it has been developing against a background of great change within society (including two world wars, globalisation, and changing attitudes and costs associated with health and wellbeing). Key factors in Australian healthcare include the combined impact of an aging population, the increased incidence of chronic conditions such as diabetes and cardiovascular disease, and increased disability rates linked to improved survival rates following serious injury. Many more people are living longer with significant disabilities, requiring an expansion of long-term care and community-based care. It is within these changing contexts, that the concept of physiotherapeutic relationships in the care of people with chronic ill
health was examined, using research and knowledge from other disciplines as well as physiotherapy to gain further insights.

In Australia, the State Health Department in Victoria commenced physiotherapy home visiting in 1947 after the Australian poliomyelitis epidemic but the presence of physiotherapists based in community-care centres and able to do home visits, did not generally occur until the 1970s (Park, 1972). Park (1972) reported that general rehabilitative care was usually undertaken by district nurses until, following work in Canada where physiotherapists were placed with district nursing services to carry out education of district nurses, similar efforts were made in Australia.

There are strong elements of this consultative role still present within physiotherapists’ work in community-based healthcare today, with an increasing emphasis on community access, continuity of care and integration of services, rather than hands-on treatment (Struber, 2003). This emphasis on education and consultancy by physiotherapists can also be related to the influence of the WHO (World Health Organization) on physiotherapy practice roles.

In 1996, Australia developed National Health Priority Areas in response to the WHO global strategy on health reform (Australian Institute of Health and Welfare, 2011). The WHO global strategy was planned with the aim of decreasing the burden of chronic disease for world communities. This aim was further reinforced with the WHO follow-up report, People at the centre of health care: Harmonizing mind and body, people and systems (WHO, 2007).

Awareness of the concepts of “self” and “other” have developed thinking about the way we exist in the world and depend upon each other for the creation of human relationships. Such discourse opened up acceptance of individual concerns as having legitimacy within the community and between people. Accordingly, for the purposes of this project, the term community-based physiotherapy and healthcare was defined as physiotherapy and healthcare provided to clients within the environment where they “learn, work, play and love” (United Nations, 1986, p. 2). This upholds the spirit of the advice expressed in the Ottawa Charter for Health Promotion:

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. (United Nations, 1986, p. 2)

ESTABLISHING THE LENSES FOR THIS RESEARCH

Just as research occurs within a socio-cultural, historical and physical context, it also occurs within the frame of reference of the researchers. To each project, researchers bring their interests, values, previous knowledge and experience and their pre-knowings. In this research the principal researcher (Diane Tasker, doing her doctoral research) and her supervisors (Stephen Loftus and Joy Higgs) brought their
insights and recommendations to this choice of research interpretation lenses. In summary, the interpretive lenses were used first, to create a series of foci to select the key elements of the complex arena and phenomenon of community-based healthcare relationships, upon which, the research would concentrate.

Practice models and professional judgement: Within the development of the profession of physiotherapy, it is not surprising that dominant views should mirror the dominant discourses present in general healthcare, medicine and society. In shaping their practice, health professionals are often confronted with the problem of how to deal with expectations of the evidence-based practice era. Tension between the way health professionals project their image when communicating with clients and the way they might be feeling about those interactions can be influenced by the introduction and development of evidence-based medicine.

Since the early 1990s, evidence-based practice and its principles have been increasingly discussed and promoted within the physiotherapy literature (Schreiber & Stern, 2005). Within this context of system expectations and dominant practices, health practitioners, as professionals, need to make decisions about what values and models of practice they wish to enact and be held accountable for through their practice. Professional judgement is a core ingredient of practice models and determines how practitioners shape their practice and practice interactions.

Capabilities and practice-based knowledge: Within community-based physiotherapy practice, where physiotherapists are “guests”, there is a particular need for “a broad array of knowledge and skills far beyond traditional notions of physiotherapy” (Heckman & Cott, 2005, p. 278). From Di’s personal experience and communications with fellow therapists, she noted that higher value can be ascribed to learning from the literature, training courses and other professionals, despite any personal misgivings practitioners might have or the possibility of alternative approaches they might have discovered through actual practice.

Actual practice includes a gradual and subjective building of craft knowledge, involving interpretation in context, in contrast with the more objective and generalised nature of evidenced-based knowledge (Higgs, Richardson, & Abrandt Dahlgren, 2004). Shaw and DeForge (2012), have argued for a similar approach to understanding how physiotherapists might view their practice, emphasising that “claims to expertise always consist of partial knowledge claims that emphasize different elements of physiotherapy practice” (p. 427) and that physiotherapists must be better viewed as “bricoleurs”, embracing knowledge from a variety of partial perspectives. Acknowledgement of the evolving and incomplete nature of knowledge could encourage physiotherapists to draw from those bodies of knowledge that are undervalued and marginalised, using philosophical and theoretical insights to explore new and varied ways to approach physiotherapy practice. An ability to draw on more marginalised knowledge can arguably enrich practice.
Chosen approaches of wellbeing and flourishing: Chronic and complex healthcare is, as its name suggests, ongoing and difficult to manage, for all stakeholders and healthcare systems generally struggle to address such complex issues (Ginter, Swayne, & Walter, 2002). Healthcare research often focuses on acute and tertiary healthcare rather than chronic/rehabilitation and low-tech community healthcare. This research was located in spaces that evidence-based practice tends to sideline; dealing with clients’ experiences, choices and feelings. It emphasised the importance of individual subjectivity rather than generalised approaches to treatment based on quantitative evidence, and it promoted the judgement of the professional as well as the use of standardised evidence in the co-creation of particularised care.

The biomedical illness and cure model frequently dominates healthcare, particularly in acute care situations. It is rarely the complete or even preferable narrative in chronic healthcare for people with disabilities. The desired effect of “wellbeing” or “flourishing” is identifiable to and experienced (often differently) by family, carers, therapists and clients. Such wellbeing transcends the physical and involves personal and interpersonal aspects of health and healthcare.

Clients and their carers will be able, in varying degrees, to take part in therapeutic exchanges and use them to promote their own wellbeing. Some clients and/or the family/carers may wish to and be capable of leading their own healthcare within their home. Community physiotherapists will need to be able to assess this desire/ability and respond appropriately, to balance both the client’s wishes and their best interests therapeutically. Long-term clients and their carers have a wealth of experience and insight; they are vital creators of their own wellness narratives.

Relationships: All branches of healthcare have gradually recognised the importance of interpersonal connections between clinicians and their clients. The term “therapeutic relationship” within such approaches is often used within the areas of psychology, nursing and occupational therapy, but within physiotherapy the literature more often uses terms such as therapist/patient or patient/therapist relationships (French & Sim, 2004). Such a dry and clinical way of describing human relationships (in healthcare) does not do justice to their complexity. Accordingly, for the purposes of this research project, the term, therapeutic relationship was defined as “a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect” (Coles & McLean, 2003, p. 33). Concern for “the self” of the client serves to place emphasis on interpersonal relationships and their potential, rather than just on clients’ biomedical conditions, clients/ bodies or practitioners’ viewpoints.
Relationships between clients, families, carers and therapists are inherently complex. This is often linked to such factors as personalities, family history, challenges in dealing with chronic illnesses and the situations (e.g. working in home/personal spaces) where community physiotherapy occurs. A deeper understanding of how such professional relationships can develop might help therapists to craft successful engagement strategies and outcomes for clients and their families/carers. Physiotherapists explore/teach/model therapy tenets to clients and carers/families via their relationships with those people. Attention paid to this tacit and under-acknowledged aspect of physiotherapy practice could improve the ability of both new and working therapists to enhance their professional practice for both their clients and themselves.

Second, three theoretical lenses were used to interpret ways that the researchers as well as the participants in the phenomenon of community-based healthcare could make sense of the healthcare situation, interactions and experiences and these same elements within the research findings. The latter was pursued through the ideas of narratives (storytelling of experiences past and envisaged), and realising the way that people often communicate their life experiences through storytelling.

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**Social constructionism: the processes of making meaning between people**

The social constructionism movement studies processes of making meaning, which occur between people as they seek to communicate with each other and establish interpersonal relationships. In particular, proponents seek to understand the conventions of language and the social processes that are used by people within human interaction. Social constructionism proposes that knowledge is not merely individually generated but also created collectively as a result of the fluid, relative and subjective nature of our interpersonal processes (Schwandt, 2003).

Social constructionism was used to inform this research because it focuses attention away from both study of individual people and the study of the external world, and towards the study of human inter-subjectivity and interaction. The methodology of hermeneutic phenomenology, chosen for this research project (see below), required iterative focusing and distancing of viewpoints to gain a holistic but deeply textured understanding of the research phenomenon. Social constructionism provides insights aligning well with this methodology.

Drawing from the field of psychology, the strategy of communicative interaction can be seen as occurring within communicative space (Shotter, 1999, 2008). This strategy allowed the research to examine conversations that occur in this space, and also how these conversations might contribute, in this case, to the way physiotherapists practise relational healthcare, for and with clients, families and carers. This fits with the argument that practitioners working in the space of community-based healthcare need to embody a new relational practice, to change what they notice and are sensitive to (as well as what they care about, and feel are appropriate goals to pursue).
Thus, we need to change ourselves, our sensibilities, the “background practices” we have embodied that make us the kind of professionals we want to become (Shotter, 1998, p. 35). One of the concerns of social constructionist thinking is to highlight different aspects of the background to our everyday life and to examine how those aspects might relate to particular human phenomena of interest (Shotter, 2008).

Narrative and the importance of interpersonal connection in healthcare
The concept of narrative recognises the storied nature of human relationships in general and clinical practice (and physiotherapeutic relationships in particular). Narratives provide us with master plots that help us to understand the usual sequence of events in relationships and how we are expected to proceed. A master plot, or story outline, has a temporal nature that can also help us understand the process of a developing relationship between people. While not employed as a major or overarching methodological strategy, the use of narratives was chosen as a powerful theoretical lens to inform this project. For this project, the work of scholars such as Arthur Frank (1995, 2002, 2004), from a background of English, psychology and sociology, and Cheryl Mattingly (1998), from a background in occupational therapy and anthropology, helped to combine views from different disciplines, offering a rich and multi-faceted opportunity to study the phenomenon of clinical relationships and reveal new knowledge about community-based physiotherapy practice. Understanding the development of clinical relationships in which participants are of various ages, cultures and personalities can be challenging but use of narrative can allow fusion of ideas between people of different backgrounds. The use of narratives within this research study is explored more fully in Chapters 3 and 4.

The chapters in Section 3 have also used stories from practice from the perspectives of different practitioners and stakeholders in community-based healthcare, lightly inspired by Geoffrey Chaucer’s late 14th century Canterbury Tales, where a traveller talks to other travellers to hear their tales and better understand them. The intent of writing these chapters in company with practitioners from many different disciplines and levels of experience can be seen as phenomenological in nature - like the Mindful Dialogues study itself, where the interviewer wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of conversation as “wandering together with” (Kvale, 1996, p. 4). The chapters in Section 3 also encourage dialogue between the authors to explore what they consider to be important issues in community-based healthcare and the relationships that develop therein.

Social poetics
Poetry often has the capacity to penetrate experience more deeply than prose (Furman, 2006). Social poetics involves the use of metaphor and other figures of speech occurring in ordinary speech and prose. Analysing the expressions of research participants with insights from poetics helps researchers enter the
complex lifeworld of participants. Appreciation of poetics helps researchers to be more sensitive to the deeply personal aspects of participants’ stories. Participants’ expressions are used to focus attention on relations between aspects of our human activities, which can go unnoticed in the everyday, busy-ness of our lives (Shotter, 1997).

Recognition and use of poetic language forms locates an essential way of being within participants’ socially constructed viewpoints, allowing us to connect with their experience. The use of poetics within the data analysis and presentation of findings in this project allowed access to unexpected and hidden thoughts, feelings and meanings from a particular participant’s point of view. By observing and highlighting the poetics of everyday speech within human interaction, researchers create rather than discover new understandings of human experience and interaction (Aldridge & Stevenson, 2001). Use of the poetic in research encourages an open attitude in readers towards the reality of another person’s experience, engendering empathy and acknowledgement of the different ways that others experience reality.

Poetics were used for different purposes within this research. Prior to and throughout the research process, pieces of free verse were written to allow reflection and a layering and deepening of understanding. During data analysis, poetic phrases “found” within the data provided meaning markers acting to promote understanding between researcher and participants. Appreciation of the poetic in the data assisted the presentation of findings via the use of “derived” poetry and also suggested points of entry for further consideration of certain issues. The use of poetics in this study enabled the phenomenon of interest to move from the local, specific and particular context of community-based physiotherapy towards wider issues of societal concern.

Finally, we looked at the way that people reading the research could best experience and “get in touch with” the research phenomenon the research was seeking to illuminate and the choice was made to engage the reader through poetics and narratives constructed from the research findings. These research communications and artefacts are discussed further in Chapter 4.

SHAPING THE RESEARCH QUESTIONS

The research was built on the argument that relational community-based physiotherapy practice occurs in situated, person-centred, therapeutic relationships, which enable clients and carers to co-construct their therapy programs and shape their healthcare journeys. The research therefore aimed to illuminate aspects of human relationships within such practice to explore how community-based physiotherapists developed reciprocity within those relationships with clients and their families and carers.
The research questions explored the participants’ thoughts and feelings about their community-based physiotherapeutic relationships in order to reveal benefits for other people in similar healthcare situations:

1. How do community-based physiotherapists experience and foster relationship-centred care within the dynamic and ongoing therapeutic relationships they develop with clients, their families and carers?

2. How do clients, their families and carers, experience and understand their ongoing relationships with community-based physiotherapists?

BASING THE RESEARCH WITHIN THE INTERPRETIVE RESEARCH PARADIGM

This qualitative research was conducted within the interpretive research paradigm and was focused on people involved in real-world activities and relationships, increasing the visibility of that world (qua Denzin & Lincoln, 2000). Such research typically deals with lived human experience. In contrast to quantitative research, which offers an interpretation of a material world that cannot interpret itself (Mattingly, 1993), qualitative research develops interpretations of an already interpreted human world. If we accept the philosophical argument that humans are essentially self-interpreting beings (Heidegger, 1962), it becomes necessary to acknowledge each participant’s views of, and contributions towards the lived phenomenon in question, in this case the healthcare situations in which they find themselves. People need to manage many serious healthcare problems by themselves. A qualitative approach to research and knowledge allows engagement with their efforts and trials.

Through “listening and talking together” with the participants in healthcare the researchers were able to reveal the tacit dimensions of the relational processes that make up community-based physiotherapeutic relationships. Researchers can better develop new knowledge for the future if they acknowledge the experience and pre-existing knowledge of the human beings participating in their research. It is not enough just to theorise from a practitioner’s point of view, we must also listen to what they and we have to say.

HERMENEUTIC PHENOMENOLOGY AS A RESEARCH APPROACH

Within this research project, participants were encouraged to tell stories about their physiotherapeutic relationships to reveal how the meaning of those relationships was managed. Phenomenology involves the study of human experience as it is lived by people (van Manen, 1990). Such studies aim to access the essence of that experience by examining the talk or writings of people from where they are located within their own perceived worlds. The complexity of human experience is then “thickly described” (Ryle, 1949, 1971) in an effort to properly consider the depth and intricacies of that essential experience.

Within the interpretive paradigm and from the range of phenomenological approaches available, a hermeneutic phenomenological approach was adopted to
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richly explore the lived experience of clients with chronic and complex healthcare needs, and the related experiences of their carers and families. Hermeneutic phenomenology allows the iterative and embodied study of lived experience, such that the findings are co-created between participants and researcher (Spence, 2001).

RESEARCH PARTICIPANTS

People caring for relatives with chronic and complex healthcare needs at home depend on their communication with healthcare professionals for support of their quite prodigious efforts. This research focused on experiences and thoughts regarding development of community-based physiotherapeutic relationships, as interpreted by clients living at home, with chronic and complex healthcare problems, families of those clients, carers for those clients and physiotherapists attending those clients. The roles and contributions of these people within community-based physiotherapeutic healthcare are inextricably linked.

This study was intentionally conducted with a small number of participants within NSW, Australia, to allow in-depth interviewing. It was decided to approach five physiotherapists in private practice (rather than salaried physiotherapists working in more institutional, community-based healthcare facilities, such as community health centres). These therapists visited clients in their homes, workplaces or recreational venues. This research decision was made with a view to accessing longer-term physiotherapeutic relationships in community-based healthcare.

Community-based physiotherapists within public and institutional healthcare tend to be less deeply placed within local communities than private physiotherapists. Community-based public physiotherapy practice also appears to be necessarily constrained by set policies related to intake procedures, amounts of therapeutic time allowed for client contact, and pressure of waiting lists. It was thought that privately practising physiotherapists might have more control over such factors and be able to monitor and respond to clients’ needs in a more individually customised way. The research was interested in the ways in which people in such situations might interpret their physiotherapeutic relationships, from all sides of that relationship. The research participants comprised:

– 5 community-based private physiotherapists in NSW
– 5 of their clients with severe chronic and complex healthcare issues living at home or in a group home
– 7 of their family members
– 6 of their carers.

The 2:3 ratio of male to female physiotherapy participants chosen for this project mirrored the overall ratio of male to female physiotherapists in general private practice, where 73% of physiotherapist were female (APA, 2005).
DATA COLLECTION AND ANALYSIS

Data Collection

Thirty-five semi-structured interviews were conducted (and recorded). Interviews held with physiotherapist participants were conducted individually and in the place where they felt most comfortable. All client and family interviews were conducted within their homes. This was considered necessary to ensure that the higher care needs of clients could be more readily and more easily satisfied during the interview processes. In some cases family members spoke on behalf of clients with speech impairments and one client used a communication augmentation device.

A focus group was conducted with the physiotherapists on their own. Meeting several times with participants helped to develop their trust when talking about the delicate issue of human relationships and how such relationships develop within home-based healthcare for complex, difficult health problems.

Data Analysis

Data analysis was an iterative process involving creation of phenomenological narratives with the participants and researcher immersion in and dialogue with the interview and focus group transcripts. From this process chunking of ideas were deeply reviewed to generate themes. Three themes were identified: being mindful, staying engaged and being responsive.

CONCLUSION

This chapter has presented the design and implementation of a study (Tasker, 2013) of the community-based physiotherapy relationships that develop between community-based physiotherapists, their clients, clients’ families and clients’ carers. The research produced rich and meaningful findings, which are illustrated in Chapter 4 and an insightful model for practice: Mindful Dialogues in Community-based Physiotherapy as presented in Chapter 5.

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