TITLE PAGE

RECOGNISING AND APPRECIATING THE ARTISTRY IN PROFESSIONAL PRACTICE: A MEANS TO RESEARCHING AND DEVELOPING PRACTICE THROUGH INSIDER PRACTITIONER RESEARCH

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Recognising and Appreciating the Artistry in Professional Practice: A Means to Researching and Developing Practice Through Insider Practitioner Research

This study explores professional practice and examines an approach to research that could be useful for the practitioner in developing and extending their practice.

The existence of artistry is recognised within professional practice (Schon 1983), and is important in making professional judgements (Fish and Coles 1998, pp. 28-53, de Cossart and Fish 2005). Therefore, as in the methodology proposed by Fish (1998), the artistic/holistic paradigm was adopted because this specifically enables the exploration of professional artistry and is suited to insider practitioner research.

The study critically appraised the use of the proposed artistic/holistic paradigm. A case study approach was used in which the researcher was the case. A portrait of an episode in clinical practice was produced, followed by a critical appraisal of this portrait. These then became the portrait of research practice, which was equally appraised. This mirrors the process seen within the arts in which critical appreciation is a reflective process, deriving its rigour from the discipline and connoisseurship of the critic.

The results demonstrate that the artistic/holistic paradigm is well suited to continuing professional development, both individually and corporately. The proposed paradigm does enable the recognition and exploration of professional artistry, both within clinical and research practice.

Professional practice has a moral foundation and it was shown that this must be openly recognised if meaningful professional development is to occur. Evidence-based medicine, which is founded on the technical-rational view of practice, was shown to be insufficient for the professional's ongoing development. This, and similar work, will impact and contribute to the ongoing evolution of the traditions of the profession.

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Author's Declaration

This study has been presented as a concurrent session at the 5th International 'Conversations' Conference in 2002 and the 9th International Reflective Practice Conference in 2003.

CHAPTER 1: SETTING THE SCENE

INTRODUCTION

In this chapter I explain the origins of this study and the reasoning behind the unconventional presentation of the work. I begin by introducing myself, the researcher. In particular, I locate where I began this research and my own professional history, with particular reference to the research tradition within which I developed. The conception and development of this study are then explained and the form described, with particular reference to the aims and methodology chosen. Certain issues regarding the methodology and the critical appraisal are more appropriately discussed at the end of this work, and a rationale for the style and ordering of this thesis is presented.

At the outset however, I need to orientate the readers to the view, or perspective, from which this research is presented, in order to enable them to appreciate it fully. This thesis contains primarily the distilled and detailed reflections of one practitioner (in this instance an Old Age Psychiatrist), on practice. These are my reflections, but they are examined from a number of perspectives and have been critiqued via theory, and the views of other practitioners. They also show a practitioner generating theory out of practice.

The strength of this work, and similar reflective works, is its provision of insight into a practitioner's reasoning and view of practice, both their individual practice and professional practice in more general terms. The views expressed therefore are very personal to me, the practitioner, but must be seen in the context of the influences that have shaped them. These influences include my education and the community of practitioners with whom I function. An appropriate questioning of my views would involve asking what has led me to form these rather than other views. This I see as a fundamental issue.

For example, my stance on evidence-based medicine must be supported by knowledge of up-to-date developments within this field (Guyatt et al. 2004; Sackett et al. 2000). But I must also show how I, and the practitioners I work with including

my supervisors, have come to view it. These reflections give an insight into the thinking of one part of the community of practitioners. The 'truth' about evidence-based medicine is not as simple as it may seem, and it has not been communicated or impacted the practice of a small, but representative group of practitioners at the coal face. The importance of this type of work is illustrating how practising clinicians are constructing their practice and what they base this on. In chapter nine I discuss the importance of collective debate to the continual evolution of the tradition of a profession. This thesis is part of that debate and the reader's response an equally important part.

This is the premise on which I ask you, the reader, to join me on my reflective journey and thus enter into the deliberations within the wider community of practitioners.

THE RESEARCHER

My own background and work, including my approach to the research, are shaped by views and beliefs that have developed throughout my life.

I qualified as a medical doctor in 1979 and then completed my house jobs before leaving medicine for several years. During this time I married and had two sons. When they were young, I returned to part time work in family planning and then to a part time post in old age psychiatry at a day hospital.

In 1991, I returned to full time work as a Senior House Officer (SHO) in psychiatry and began my postgraduate training. During my initial training posts as a registrar I worked with the Elderly Mental Health (EMH) team, with which I later commenced this study. This was at a time when the team was based in one of the old-style institutions that was in the process of being closed. Many of the team members have changed since then but I have always felt that the ethos remained the same and I was attracted to the team's patient-centred focus. After passing my membership exams, I returned again to work with them as a Senior Registrar.

By now the team had been relocated to a community hospital with new inpatient facilities. However, the culture of the team remained unaltered. This placement was at the beginning of my higher training and following this I worked with several other teams, giving me an opportunity to consider different ways of practising. I returned to the EMH team in 2000 as a consultant and continue to work with them today. The reason for choosing to return was the fact that I liked the way it functioned and felt it provided genuine patient-centred care. During my time with them, I commenced this piece of research, which has continued up to the present time. The actual fieldwork, the interviews with the patient and team members, was completed while I was a Senior Registrar working with other psychiatric teams.

My medical training was at a university in the south of England. In the curriculum, certainly at that time, there was a strong emphasis on research and all students undertook an in-depth study during their fourth year. We were grounded in the ideal for research, namely the randomised controlled trial. All other research was seen as less reliable. Looking back now, I see that the teaching was within the Positivist Paradigm. I did not, however, realise this was the case and I was not aware of the paradigm debate which influenced the choice of methodologies. The underlying belief within the Positivist Paradigm is the existence of an immutable reality and the purpose of research is to comprehend this. The researcher seeks time and context free generalisations which enable a better grasp of this reality, through the verification of hypotheses. The validity of research findings depends on the objectivity of the experiment and central to this is the detachment of the researcher.

The in-depth study I chose was an observational study in geriatrics looking at autonomic functioning and whether this could be correlated to changes in heart rate, which might then be used as an indicator of the risk of falls. I am still not sure what I learnt from this experience, except perhaps how boring research could be. I often wondered what relevance or use it was to clinical practice and now, with hindsight, I recognise that this is a question practitioners frequently ask.

In postgraduate education, research is seen as essential. In some specialities, the trainees would be expected to have several research publications when they apply for a consultant post. This is more variable within psychiatry, but trainees would

certainly be expected to show an interest in research and to have carried out some during their training.

As a registrar, I conducted a postal survey of patients who had received psychotherapy to look at how often psychotropic medication was used alongside psychotherapy. I chose this for several reasons. Firstly, I was particularly interested in psychotherapy. Secondly, I had limited time in which to do this project, therefore it had to be manageable. Thirdly, I felt this issue was important clinically. I had been involved in many discussions regarding the appropriateness of patients being accepted for psychotherapy if they were on medication. The study was time consuming with no clear outcomes, and I didn't even get it published.

The expectation for research to be undertaken is even more explicit at Senior Registrar level. Trainees are allocated one day a week for research/study, and they are called periodically to attend the research committee to outline exactly what they are doing. I therefore came to the point where the current piece of work was conceived. I was definitely disillusioned with research and regarded it as just another hurdle to get over on my way to a consultant post. My attitude was very negative concerning research for the clinical practitioner, as I did not believe it had any relevance for everyday practice.

I am approaching this research as a practitioner and reflecting on my practice. Therefore the views I express will be personal to me and related to the context within which I practice. For example in relation to evidence-based medicine I outline quite a few concerns about relevance and benefits to practitioners because from my experience and discussion with colleagues it appears firmly based within the positivist paradigm. There seems to be a denigration of other forms of 'truth'. However, I am aware other practitioners, especially those within an academic context, would contest this and in their opinion feel it does allow for other 'truths' to be acknowledged (Downie and Macnaughton 2000; Greenhalgh, T. 1996; Muir Gray 1997). The important issue, which I discussed earlier, is not that either view is right or wrong, but rather the view I present is how many practitioners perceive evidence-based medicine and therefore the influence it has on their practice.

I have outlined in some detail my professional history because no one, including the researcher, can be seen in isolation from their context and the influences that have shaped their perspectives and outlooks. The researcher's background is relevant to the approach taken to the research question, and was particularly pertinent in this study.

Fish and Coles (1998) present, in the book they edit called 'Developing Professional Judgement in Health Care', a series of reflective case studies from a group of health care professionals. One aspect that comes across strongly in this collection is the need to appreciate where these professionals came from when they began this episode of reflection. If the readers were ignorant of this, they would not understand the journey taken because they wouldn't appreciate the researchers' starting point. Likewise, in this piece of reflective work, the reader needs to understand my background and starting point. Usher et al comment, concerning this aspect:

> Practitioners are not just bounded by an 'action present', but are historical actors. Their theories-in-use are cultural as well as personal artefacts.
> (Usher et al. 1997, p.169)

As Usher et al. point out, I have both a personal past and a cultural heritage and am shaped by the traditions of the profession which I have entered. These factors will influence my reflections, and that is why I have taken this opportunity to introduce myself as I set the scene for this work. In chapter five I will give further autobiographical details that are relevant to the reflections on the research process.

THE RESEARCH FOCUS

Here I outline the development of the research focus of this work. Unlike the positivist researcher, I did not set out with a fully formulated question. Rather, I started with an idea about a needs-led service from which some initial questions presented themselves. As the study developed, so did the issues I was considering and the questions arising from them. This was an ongoing process throughout the research and only resulted in a fully formulated question at the end. To understand

fully what I was seeking, I first had to find it. The discovery of the research question or focus was as much part of the actual research as any other part. I would argue that all the other research work was in fact groundwork to enable this to occur. For much of the time it felt as if I was walking through a fog. Sometimes I could make out forms and at other times the fog would clear temporarily and some aspect would become very clear, but then disappear again. It reminded me of walking up Snowden and never knowing if I had reached the summit until I actually did.

There needs to be an appreciation of the 'fog' during that journey to reflect on it, though not a need for the reader to experience that 'fog' first hand as the researcher did. Therefore I explain at the outset the rationale for the research approach adopted, even though this only became clear as the study proceeded. The full details, including the research/audit trail and appraisal of the methodology, are located at the end of this study in chapters five, six and seven.

At the start of this study, although I didn't realise it, my views of science were firmly based in the positivist paradigm and were about to be challenged. There is an assumption that there is a definitive reality to be discovered that can be formulated in time and context free generalisations. The purpose of research is to reveal these truths. The methodology revolves around the testing of hypotheses, and there is an assumption that the investigator can remain independent from the investigated (Guba and Lincoln 1998). These beliefs are fundamental to the randomised controlled trial which is the gold standard within evidence-based medicine. Schon and Stanley (2003) explore the philosophical basis of evidence-based medicine and make the point that it is important to define evidence-based medicine by the factors that clearly distinguishes it from other approaches to medicine. They conclude:

> What separates EBM from other approaches is the priority it gives to certain forms of evidence, and according to EBM the most highly prized form of evidence comes from RCTs (including systematic reviews) and meta-analyses of RCTs. (Schon and Stanley 2003 p. 3)

This does not preclude the recognition of other evidence but in my experience since the advent of the evidence-based movement within medicine it is not accepted or valued to the same extent. Therefore even when practitioners, I have worked with, acknowledge other paradigms the 'truths' these demonstrate are under-rated if not rejected. Most practitioners however, are unaware of the paradigm debate and I certainly was not until I embarked on this piece of research.

Fortunately, I came into contact with researchers from related disciplines working in other research paradigms. This resulted in discussions that began to challenge and extend my concept of research. Through skilful supervision, I was able to reflect, critically appraise, and develop my practice. Initially, this referred primarily to my research practice, but as the study unfolds it becomes evident that it also includes my clinical practice. This has culminated in the formulation of the research aim, which is:

> To determine how research can be meaningful and relevant to practitioners.

The reader will recognise that this is the question I asked myself at the end of my fourth year study in medical school, and I have since realised many practitioners echo this sentiment.

This work has developed into a case study and, as the researcher developing my practice, I am the case. I am primarily a practitioner located firmly in everyday clinical practice and not within an academic context where research might be my primary area of practice. I am typical of many medical practitioners in both my obligation to undertake research, and my disillusionment with the relevance of this in relation to my everyday practice. The case is therefore not unique and, because of this, does have relevance to other practitioners, which is a prerequisite for a case study (Golby 1994).

The method of inquiry used was reflection. Within this work there are multiple layers of reflection and each one interacts with the other. This is complex and sometimes appears messy, but I make no apology for this because it reflects the situation in practice. Indeed, what I am presenting in this thesis is research practice as opposed to

research theory. Out of the practice, theory will emerge and be modified over time, but the practice has primacy. This is insider practitioner research, firmly based within and focused on the researcher's own practice and is contextually based. This does not mean that formal theory is irrelevant or has been ignored, but means it has been linked into practice and considered as the practice dictates. The expectation for most medical research would be for the theory to dictate the practice and for the research question to be clearly stated at the outset. This can be seen not only in the published studies in mainstream journals (such as the *British Medical Journal*) that adhere to the positivist paradigm, but also in studies based within the interpretative paradigm. I am therefore aware that I am challenging many assumptions taken for granted within the medical world regarding research and how it should be both formulated and presented. There is also a sense in which I am pushing the boundaries of acceptability within academic circles.

The levels of reflection could be visualised as ever increasing circles from a central point, rather like the effect of dropping a pebble in a pool of still water. At the centre, the first case for reflection is Elsie and her story: a patient referred to the EMH team. The next level out is the team's professional practice and judgement in this episode of care. To explore this with the team, I engaged in reflective discussions with each practitioner who came into contact with Elsie. Alongside this are my reflections as a practitioner meeting Elsie and my own professional judgements. There is then a bringing together of all of these levels of reflection to formulate my own professional judgment and view of this episode of care. This is titled *Reflections* within the portrait.

The process is mirroring the processes that would be occurring in my everyday practice as an Old Age Psychiatrist. I would be engaging in all of these levels of reflection to formulate my professional view of the case. The discussions with the team members involved in Elsie's care are central to this process and do demonstrate, I would argue, multidisciplinary working. It is important to appreciate that in this work I am not having these discussions with the other practitioners to primarily demonstrate their professional view of Elsie's case but rather to demonstrate how interacting with them and hearing their views contributes to my judgments. This is why this work is exploring my professional practice not the team's practice.

Therefore, it is important to remember that the views expressed are personal to me. Up to this point, all the deliberations and reflections are focused on comprehending Elsie, the patient. This stage is rooted in clinical practice and the reflections arising from this process.

Moving out from this centre, the focus shifts to reflection on the professional practice itself and those specific areas, which arose as I considered Elsie's care. These were issues that seemed pertinent to me, the practitioner, and my professional practice. Therefore, another practitioner involved in Elsie's care and reflecting on their practice might have felt other issues were pertinent to their practice. The majority of this can be found within the critical appreciation in chapter three and chapter four on professional practice. At this juncture, formal theory and the literature are drawn on to inform the reflective process. The various uses of the literature are examined in chapter seven on methodology.

I have been seeking out 'practitioner-serving' research to inform my practice and aid my development. The initial levels of reflection show me in the process of researching my clinical practice with the EMH team. At the outer circle, I am reflecting on the research practice itself to answer my research aim.

From these circles of reflection, several research questions have crystallised, which contribute to the realisation of the research aim. These are:

1) How can we research our professional practice?
2) Can we express and appraise the artistry in our practice?
3) Is the artistic/holistic paradigm, proposed by Fish (1998), a suitable means for this and, if so, how might it be developed?
4) What role would the artistic/holistic paradigm have in professional development?
5) How was my clinical and research practice impacted by this study?
6) How might it affect other practitioners?

Research Approach

At this point, I am only giving an outline of the research approach to enable the reader to navigate this study. A critical appraisal of the methodology will be offered in a later chapter.

I have chosen to adopt and critically explore the methodology outlined by Fish (1998) arising from the artistic/holistic paradigm she proposes. My reason for choosing this was that the methodology is firmly rooted in the professional artistry view of practice and presents a means whereby it can be fully appreciated and explored.

Artistry has been recognised within professional practice on one level. Specifically within medicine, Dixon et al. (1999), Frank (1995), Heath (1995), Kleinman (1988) and Lown (1999) acknowledge the art inherent in the practice of medicine. Nursing recognises the artistic nature of practice and is more explicit in the discussion of it. Johnson (1994) conducted a review of the literature on nursing art and from this identified five distinct concepts of artistic practice. Diers (1990) grapples with articulation of the art of nursing as a whole: rather than trying to reduce it to its component parts, she employs artistic means, namely metaphors, to do this. In the field of education, Eisner (1983) likewise uses metaphors to convey the artistry of teaching when he compares teachers to the conductor of an orchestra.

There has also been recognition of artistic processes within qualitative research. Wolcott (1994) in his book *Transforming Qualitative Data* takes his earlier works as case studies to examine his research practice. He then conveys a way of thinking to enable the readers to develop their own style of ethnography within a framework. His work is not prescriptive but, I would suggest, artistic. I think he is seeking to transmit something of this artistry to his readers even though this is not explicitly stated. Delamont (1992) discusses fieldwork in educational settings. Her work does convey the artistry inherent in this and, interestingly, she uses a poem as a metaphor to facilitate her communication of this.

Geertz (1990) discusses the need to acknowledge and explore the role of ethnographic texts in conveying the information acquired during the anthropologists' fieldwork. Anthropologist's of course work within someone else's community in order to 'render the familiar strange'. In that sense they are engaged in a different enterprise from mine. However, Geertz suggests that the skill to convey through the writing that the anthropologist has indeed been immersed in and understood the culture being described, is as important as the information gathered. This is closely aligned to Fish's (1998) work and is beginning to introduce the idea of examining the artistry within the process of writing (but as an outsider to the community researched) in order to enable an experience of the practice, in this instance the anthropologist's fieldwork to be captured in its vivid reality. Through his examination of anthropological texts he discusses the use of literary techniques including imagery and phraseology. I think you could argue he is engaging in a critical appreciation of these texts even though this is not acknowledged. Artistry is being alluded to within the texts and perhaps more obliquely within the original fieldwork but is still not addressed directly as I feel Fish does.

Eisner (1981, 1995 and 1998) explores the artistry involved in qualitative research more specifically. He begins to develop the ideas of using the techniques within the arts, namely connoisseurship and criticism, to further the understanding of educational practice, but stays firmly within the recognised methodologies. He appears to pull back from taking the next step, which is to fully embrace the means within the arts to explore the art and artistry of practice.

Likewise, Golby and Parrott (1999 p.45) argue for an 'eclectic case study approach' to facilitate an appreciation of the complexities of professional practice. In their work, they demonstrate the inadequacy of the technical-rational view of practice and illustrate the many complex factors within practice. Rather than developing an alternative view, or paradigm/methodology, they remain with those already recognised and advocate a pragmatic use from each. There appears to be an assumption that this will enable the true nature of practice to be captured. Despite discussing many aspects of practice that point to the inherent artistry, and despite advocating the need to see practice holistically, artistry itself was only implied.

Fish (1998) takes the necessary step. She argues for an artistic/holistic paradigm whereby the artistry within professional practice can be recognised and explored. This paradigm enables the ineffable and mysterious parts of practice to be given 'a voice', which often requires the use of figurative language. Now these aspects can be critically appraised instead of being barely recognised or not acknowledged at all:

> In this model, then, the professional is not less accountable, but is in fact accountable for more – for skills of course, but also for much more important moral and ethical matters that underpin their decision-making and judgement.
> (Fish and Coles, 1998 p.34)

This approach opens the way for meaningful accountability of professionals rather than the regulatory approach I discuss in chapter four on professional practice. Fish and Coles (1998 p.57) talk of professionals 'giving an account of their practice', and they emphasise that this type of account will go much further than the requirements within audit and individual performance reviews (IPRs). As I shall argue, this paradigm, or methodology, is the ideal means for ongoing professional development. All aspects of practice are recognised, including the technical-rational parts, but most importantly this approach opens up other areas hitherto disregarded or hidden. Once made visible, they are available to critique and can then be developed.

The Artistic/Holistic Paradigm or Methodology

I am calling this a paradigm in line with the work of Fish (1998). At the same time, I do recognise that the establishment of a new paradigm is contestable, and the standing of 'established' paradigms continues to be hotly debated. The review by Hammersley (1992), aptly named 'The Paradigm Wars', demonstrates this and illustrates the complexities of the philosophical arguments inherent to this discussion. Further work and debate is necessary to establish whether Fish's proposal is indeed a paradigm shift or an alternative methodology. In this thesis I am not proposing to enter into this debate, important though it is, because this is not the purpose of this enquiry. However, my view is that this is a paradigm shift because it presents an alternative worldview of professional practice. The knowledge sought is the artistry

within practice and this is the perspective through which practice is seen and evaluated.

Art is creativity, something which did not exist before is brought into being. An artist uses what is available around him or her to create his or her work of art. That work of art can bring pleasure to those who engage with it. In my opinion a practitioner creates a 'solution' for their patient, this is unique and specific for each individual; this is their work of art. If it is truly a work of art this brings 'pleasure' or 'healing' for the patient. I will be elaborating further on my view of healing in chapter three. This is how I see my practice and why I adhere to a worldview of professional artistry.

Art is about creating and therefore is a process. This is why I think the artistic/holistic paradigm is a significant and unique development because it specifically explores and appraises this process – the artistry. Other paradigms, in my opinion, acknowledge the work of art and the operation of artistry but lack the ability to truly explore and develop artistry. As I discussed in the previous section Eisner (1981, 1983, 1995 and 1998) exemplifies this particularly well in his work.

An important concept within this paradigm is appreciation, taking the role of the art critic to open the eyes of the audience to the piece of art. This is discussed in detail in chapter seven. Confusion can arise through the use of the word appreciation and the sense within which it is used. Appreciation does mean recognising and valuing something of worth, however what is being valued and how it is being judged to be of value can of course vary widely.

Appreciative Inquiry has developed from action research and organisational development:

> Appreciative Inquiry is deliberate in its life-centre search. Carefully constructed inquiries allow the practitioner to affirm the symbolic capacities of imagination and mind as well as the social capacity for conscious choice and cultural evolution. The art of appreciation is the art of discovering

> and valuing these factors that give life to a group or an organization. The process involves interviewing and storytelling to draw out the best of the past and set the stage for effective visualization of the future.
> (Cooperrider, Whitney and Stavros, 2004 pp. 3-4)

Appreciating what is good within an organisation is central to this approach but this is firmly rooted in a social constructionist view. Reed et al. (2002 p.38) point out that the appreciation in this approach 'is directed towards appreciating what it is about the social world that is positive'. The participants debate the worth of the current social world they inhabit and agree together their view of the ideal they seek. By contrast, the artistic/holistic paradigm explicitly recognises and judges worth against artistic standards.

Furthermore a central tenet of Appreciative Inquiry is its collaborative stance with all involved. This is quite right when a social constructionist view is sought. However, within the artistic/holistic paradigm the view and vision sought is that of the artist. It pursues an artistic view. Eisner discussing artistic approaches to research comments:

> - one doesn't really want the mean view of four writer's observations about the mental hospital in Oregan which served as the subject-matter for Ken Kessey's play. One simply wants Ken Kessey's view.
> (Eisner, 1981 p.6)

Likewise in this paradigm one is seeking the practitioner's view or vision of his or her practice. This is sought to demonstrate the artistry within his or her practice.

Unitary Appreciative Inquiry has many similarities to Appreciative Inquiry although it developed independently within nursing and has the science of unitary human beings as its basis. Within this form of inquiry the practitioner seeks:

> - to use the metaphysics of the unitary perspective as a means of viewing, seeking, and envisioning human life and

> possibilities. This orientation requires taking a stance toward inquiry that extends the vision of possibility for all participants.
> (Cowling, 2001 p.33)

The unitary perspective seeks through pattern recognition within human life to comprehend the singular pattern that enables an appreciation of the essence of a particular situation. The 'pattern appreciation' is central to this stance and Cowling (2001, p.33) says 'the referent point is the field pattern of that entity' whether the entity is an individual, group or society. Adopting this perspective facilitates the exploration of the richness of human life and allows for the possibility of change if agreed by the participants.

As with Appreciative Inquiry the means employed in unitary appreciative inquiry can include creative enterprises such as story telling or poetry. This does not necessarily mean that artistry is being explored and indeed in this instance artistic tools are primarily being used to illustrate patterns of human existence or the 'underlying human life pattern' (Cowling, 2001 p.38). Once this has been agreed collaboratively then the participants can explore the possibilities of transformation and the inquiry moves into an action research stance.

Therefore although on first consideration these two forms of inquiry may appear to be similar to the artistic/holistic paradigm there are fundamental differences, which render these approaches less appropriate for my purposes.

I adopt the artistic/holistic paradigm to examine it within a practical situation. In other words, I use this in my research practice and then evaluate its usefulness in fulfilling my requirements. The requirements are to enable research to be meaningful and relevant to practitioners. This reflective process, or evaluation, is the outer circle of reflection.

I argue strongly throughout this work that the professional is an artist and professional practice is a creative activity. If this proposition is accepted, then it is

appropriate to turn to the arts to consider how artists explore and develop their work. This is the central tenet to Fish's (1998) proposal for the artistic/holistic paradigm. In her work she argues that artistic means need to be employed to enable the artistry of practice to become visible. Given the nature of the phenomenon, 'artistry', that is being sought, not surprisingly traditional 'scientific' means are inadequate. The language of the arts can enable a holistic picture of practice to emerge, including the ineffable and mysterious elements. This is not about analysing or reducing these aspects so that they can be categorised, as in a scientific approach, but is about becoming aware of their operation. Professional practice is a complex activity with many facets operating simultaneously, and a wholeness, or completeness that transcends these individual facets. That the whole is greater than the sum of the parts, though much quoted, is nonetheless apt. Therefore, figurative language can be employed and indeed may be the ideal medium for conveying these concepts. Fish describes the use of figurative language succinctly:

> Rather it is used here to describe those elements of practice which are hard to sense, or hard to capture in any simple concrete description. This might be because they are nuances or fleeting thoughts and feelings, mere tinges on solider colours, or because so many things are happening at once during a particular incident (or because ideas are needing to be held together in an overall unity) that there are matters which cannot be grasped by simple, chronological description. As poets have always known, an image, by contrast to more pedestrian description can convey a complicated mixture of vision, emotion and idea *in one instant.*
> (Fish 1998, p.235, italics and brackets in original)

She conveys the ineffable which practitioners are so often aware of but unable to express, and signposts a means to begin expressing and therefore exploring these important aspects. The ineffable aspects are those things that cannot be expressed directly in words. A point she makes earlier is that such aspects are quite distinct from elements of practice that are hidden because they are below the surface and subconscious, which once brought to the surface can be expressed and discussed in more conventional terms.

Some of these elements which are below the surface, but amenable to articulation once they are recognised, will include all those outlined in the 'iceberg of professional practice' described by Fish and Coles (1998, pp. 305-306). They also include theories in action, often in contrast to our espoused theories discussed by Eraut (1994). Within this proposed paradigm, all of these are recognised and explored. Indeed, other authors (Eisner 1998; Golby and Parrott 1999) proposed that research should do just this, but they overlook the ineffable aspects and this is the distinguishing feature of Fish's proposed paradigm (1998).

Recognising the holistic nature of a piece of practice is vital to fully comprehending that practice. Atkinson (2000) points out how visual imagery is frequently employed when a practitioner attempts to operate at a holistic level within practice. This is seen in the portrait of Elsie where the metaphor of her journey is employed. If, in everyday practice, visual imagery or figurative language is used, then there should be a willingness to use this to gain a holistic perspective of our professional practice. A useful metaphor used in the literature is 'the iceberg of professional practice' (Fish and Coles, 1998 pp. 305-306). This conveys all the aspects influencing professional practice and how much remains hidden in comparison to those easily visible. Using this metaphor conveys a wealth of understanding within a few minutes, whereas to convey this same understanding in a 'scientific' format would not be possible.

Eisner (1998 p.31) quotes Dewey (1934) who believes that 'science states meanings and art expresses them'. In other words, science points directly to the thing it describes and seeks to represent the object, frequently through mathematical formulae. In contrast, the arts use forms to present the experience directly to their audience, through a painting or a poem for instance. It is not a literal representation but offers an experience of a phenomenon. Hence, abstract art may bear no resemblance to its subject but expresses something of that subject's meaning. Another way of viewing this would be to think of art as offering something of the lived experience rather than just describing it.

There is, therefore, a shift within this paradigm from a scientific viewpoint to an artistic viewpoint, and we need to appreciate the difference when judging this

research. This aspect is developed further in chapter six. As I keep emphasising, probably because of my own background and the traditions of the medical profession, scientific truth is not abandoned but is seen as another form of truth; artistic truth is different but nonetheless valid. We are viewing practice through an alternative lens, which seeks out artistic truth. Both these truths should inform professional practice. Importantly, the artistic/holistic paradigm embraces the scientific view of truth when appropriate and is inclusive of all that has gone before and extends beyond it.

Over recent years, we have largely ignored the artistic truth to the detriment of our profession and most importantly our patients. McNiff states:

> Without the pressure resulting from the imposition of one way of looking at the world onto every research opportunity, science and art will be free to interact naturally and collaboratively as they have done throughout history.
> (McNiff, 1998 p.33)

He argues that art therapists need to use the creative arts to research their practice by artistic means rather than being forced into a scientific-based view of research. However, his arguments have a wider application to professional practice in general when the artistry inherent in practice is recognised. There is undoubtedly the requirement for science and art to collaborate in the exploration of professional practice.

As well as adopting the language of the arts and their view of truth, Fish (1998) advocates the adoption of their methods. The artist works painstakingly over many drafts before completing a final work. Throughout production, the work is critically appraised and subsequently adjusted until it expresses what is meant to be conveyed. The artist reads the situation or has a conversation with it. On-the-spot experimentation guides the next steps. Although the artist begins with an impression of what to paint, the end will not be known until it is reached.

To develop as an artist involves critically appraising one's own and other artists' work. This occurs both individually and in debate with other artists. In this there will

be an appreciation and recognition of the traditions within which they work and how they relate to what has gone before.

Research into professional practice needs to be seen as an artistic endeavour. Fish (1998) suggests that the practitioner should produce a portrait of an episode of practice. This is a specialised form of case study but the practitioner/researcher is free to use artistic means, including figurative language, to convey the experience of practice rather than merely describe it. An artistic process will ensue similar to that described for the painter.

The work that follows is firstly a portrait of a piece of practice, in this instance, Elsie's episode of care with an EMH team based in the south of England. The second part is a critical appreciation of the portrait, in the same way that an art critic would produce a critical commentary on an artwork. There is no one standard set of procedures to follow; the critical appreciation itself is a work of art. Any means is permissible, within the artistry of writing, to draw out aspects of the portrait and therefore, ultimately, the professional practice on which the portrait was based. This can include formal theory and certainly does not exclude discussion of randomised controlled trials if relevant to the critic's intentions. As well as considering various aspects there will also be a consideration of the whole portrait; a holistic view. The practitioners are opening up to themselves and their audience the professional practice presented in the portrait.

The critical appreciation takes up two chapters within the thesis. Chapter four, on professional practice, is separate because it considers the wider implications for the medical profession of the issues arising within the production of the portrait and the earlier parts of the appreciation. This chapter can also be viewed as the point of transition to the reflections that follow on the research practice itself. Within the traditions of this methodology I suggest that there is a second portrait, which is the portrait of the research of the clinical practice. This is then followed by another critical appreciation of this portrait.

The critique of practice is important and raises a question concerning the artistic/holistic paradigm. Is this fundamentally different from critical inquiry? One

of the main aims here is to change or improve practice through critically appraising it:

> For this reason, critique is aimed at revealing to individuals how their beliefs and attitudes may be ideological illusions that help to preserve a social order which is alien to their collective experiences and needs.
> (Carr and Kemmis 1986, pp. 138-139)

The critique of practice would be focussed on those aspects of the social world within which practice was occurring that were constraining or limiting that practice. Fish (1998, p.122) warns against confusing the critical appreciation within the Arts that she is advocating with the critique employed within critical theory. The focus of the critique within the Arts is on the creativity inherent on the work being considered, likewise the critical appreciation advocated in the artistic/holistic paradigm is primarily focussed on the creativity within the professional practice.

An important element of a critical inquiry is the political and historical basis within which the social world we inhabit resides. Inherent within critical inquiry is a search to challenge and emancipate the participants from the taken-for-granted powers, which leads to action that critically transforms society. Golby and Parrott, in their overview of the different inquiry paradigms, summarise this well:

> There is no escape from power and political interest, because our world, our knowledge of it and our ways of thinking about it and acting in it have all been constituted by different 'interests'.
> (Golby and Parrott 1999, p.53)

We cannot ignore the effect of political influences on practice but, unlike critical theory or inquiry, they are not the focus of attention within the artistic/holistic paradigm. However, within critical theory this is the central issue:

> Research thus becomes a transformative endeavour unembarrassed by the label 'political' and unafraid to

> consummate a relationship with an emancipatory consciousness.
> (Kincheloe and McLaren 1998, p. 264)

Kincheloe and McLaren state this unequivocally and capture the essence of critical inquiry. Through raising awareness and understanding of the influences determining our social world the researcher seeks to free the participants to transform that world, the inquirer can be seen in the 'role of instigator and facilitator' (Guba and Lincoln 1998, p. 211). An awareness of the political influences on my professional practice and willingness to challenge these is of course important in the ongoing development of my practice, but it is only one aspect. More important from my perspective of everyday practice, is understanding and developing the artistry within my practice to enable me to truly create the unique solution for the individual who consults me.

The political issues can be and are acknowledged within the artistic/holistic paradigm as are many other facets that could not be addressed within the critical theory paradigm. For instance, within this work I have considered the ramifications of the ever-increasing government regulations and demands for accountability on the medical profession. Likewise I challenge the accepted view of the supremacy of evidence-based medicine in its current form but again this is just one part of the work and not the main intention, which is to explore the artistry within professional practice.

There are times also when we need to recognise and understand the 'beauty' of good practice and celebrate it. This is the aspect unique to the artistic/holistic paradigm. Change for the sake of change is equally detrimental to patient care as a lack of critical appraisal. There is a need to articulate what went well and why, and so help inspire artistry in other practitioners. I use the word 'inspire' because examples cannot be copied; it is always a creative enterprise. Through this paradigm, a balance is restored in reviewing practice, which promotes true appreciation. This is essential both for practitioners, who perhaps more than ever feel undervalued, and society, which needs to comprehend the work of the professional.

Writing and Presentation of the Study

I will now turn to explain both the ordering of the work and the styles adopted within it.

The writing and presentation were as much part of the research as any other part and, as I stated earlier, works of art in themselves. The way this work developed and the final presentation forms another portrait that demands a critical consideration. These aspects are a reflection on the writing process. The reflection on the textual presentation is an important element of a reflective stance on practice, and the lack of this in Schon's works is a criticism highlighted by Usher et al. (1997).

The writing process has been an important aspect for me as the researcher, especially in the earlier drafts, as it enabled me to develop fully the ideas that were emerging. However, as I have progressed to the final piece of work, the emphasis has changed to the needs of my readers. This is especially pertinent in the use of the artistic/holistic paradigm. Within this paradigm, the practitioners/researchers seek both to develop and to communicate their practice. Even if the work was in the form of a personal portfolio primarily for the practitioner's own use, the articulation of practice is still a central part of that. In the context of my work, this is of course even more important.

Within the work, a variety of styles are evident. The work includes my reflections as a practitioner engaged in practice within the areas of clinical work, research and writing a thesis. Therefore, because this reflects my thinking and conversation with myself, the reporting style adopted is conversational so as to include the reader in those conversations. I hope the reader experiences this work as a conversation between two practitioners. Another pertinent factor is that I practise in medicine where the oral tradition predominates, hence a conversational style is my natural habitat and will be for many of my fellow practitioners reading this work. The conversational style is useful in opening up this area of practice by offering the opportunity to join in this conversation.

Golby and Parrott (1999), considering the case study as a means of educational research, emphasise the requirement for a variety of reporting styles to be adopted. This is discussed with particular reference to dissertations. They point out that often the researcher is part of the case study, and therefore 'writing styles cannot be restricted to the cold third person' (p.95). At times, when a link to formal knowledge is being explored, they advise that a more formal abstract style should be used. This work is a case study and I have endeavoured to adopt the most appropriate style to the varying tasks in hand.

I have purposefully chosen not to present this work in the conventional order expected within a thesis. The episode of practice, or portrait of practice, and its critical appreciation are presented first, followed by a discussion and appraisal of the methodology adopted. This reflects the research process and remains true to the actual practice that occurred. I am arguing that practice has primacy of place and out of this the theory arises. Therefore it would be inconsistent to reverse the order in the reporting of this research.

Conclusion

I have spent some time explaining the development of the research focus and how this has influenced the presentation of the work. Many of these themes are revisited and developed later within the thesis but have been briefly considered here to set the scene for the reader to understand what follows. Ethical issues are also important in any research endeavour. These are discussed in detail in chapter five in relation to the fieldwork, and in chapter seven in relation to work within the artistic/holistic paradigm. I have chosen to locate these discussions at these points because I feel they are more appropriate for the reader, rather than discussing them here, where they could feel out of context. In concluding, I would again emphasise the developmental nature of this work which centres on a reflective process and echoes the words of Fish:

> Serious reflection on practice does not replace one dogma with another. It is something that one learns to do as one proceeds. Such

> research is itself an artistic process where neither the ends nor *the* specific ends can be pre-specified.
> (Fish 1998, p.59, italics in original)

SUMMARY

My aim in this chapter has been to set the scene for the reader. This is to enable you to embark on a journey of reflection as you read this work and become privy to the journeys of reflection that I the researcher and the professionals working with me embarked on. I have set in place the landmarks necessary to orientate you and would now invite you to join the reflective practice.

CHAPTER 2: PORTRAIT OF PRACTICE – ELSIE

This study or portrait is my reflection on an episode of professional practice that took place within the EMH team. I have chosen to examine in detail one piece of practice to illustrate how my professional judgments are formed in everyday practice. The focus is on my professional practice rather than the patient's story, although obviously it is an important element. Equally although the other practitioners' views are important and do contribute to my own professional judgment this portrait is one Old Age Psychiatrist's exploration of their practice. The vision presented is personal to me. Another practitioner involved in this episode of care would not create an identical portrait; there would be similarities but also significant differences. One way of viewing this portrait is that I am presenting to you a story of how I come to form my professional judgments in my practice.

I have chosen to present these reflections as a portrait because I am seeking to convey my vision of the artistry inherent in professional practice. This introduces important distinctions between this work and other work the reader may be more familiar with. One fundamental issue is the nature of the data. In a more familiar qualitative study this would be the information, and therefore direct quotes, from the informants. However, in this genre this is the background material and the data is the actual creation and reworking of the portrait to capture the 'essence' the artist seeks to illustrate. This will be elaborated on further in chapter six. Therefore quotes are not used to justify each point put forward rather they will be used to serve a rather more artistic purpose in adding to the vision being portrayed. This work is not an ethnographic presentation and it would cause confusion if it was approached as such.

INTRODUCTION

Firstly I introduce this piece of practice by placing it in context and explain Elsie's medical diagnosis. Then I look in more detail at the research process involved and my role as a researcher and fellow practitioner. Following this, I relate the events that took place and the perspectives of the professionals involved. This includes their views on the professional practice, and intertwined in this are my reflections and

professional judgments on the case. Finally, I draw together some of my thoughts concerning this case study and the implications I feel this has for my own professional practice and may have for fellow practitioners.

Elsie, a woman in her late 70s, was going through a difficult time and was referred to the EMH team by her General Practitioner (GP), who no longer felt he could provide the level of support she required. Elsie's medical diagnosis is an agitated depression. As a psychiatrist, I estimate that such a diagnosis constitutes about 40% of my cases. It is a common condition, typically seen in elderly people. The low mood is usually accompanied by several characteristic symptoms. These include loss of appetite; often, but not invariably, weight loss; and difficulty sleeping in the early hours of the morning. There is a marked loss of interests, and the patient relates feeling much worse in the mornings, with some improvement as the day progresses. The distinguishing feature is anxiety or agitation. They may not be able to sit still and constantly seek reassurance, even in the middle of the night, from fraught relatives or sometimes by calling their doctor out. They can be convinced they have some illness and are unable to accept any reassurance, describing severe anxiety feelings, often in the form of panic attacks. When their GP becomes involved, often a vicious circle becomes established, which hinders the effective treatment of this disorder. Whatever antidepressant the GP prescribes, the patient quickly stops before it has a chance to work because they are convinced they have all the possible side effects, and become even more anxious about these. At this point, everyone involved with the patient feels desperate and this is usually when they are referred to the EMH team.

From a clinical point of view, Elsie's case is typical of our everyday practice. It is therefore ideal for a case study because it fulfils the requirement to be of the particular, rather than the unique (Golby 1994). This case has been selected to illuminate aspects of professional practice within elderly mental health care and beyond that to the exercise of professional judgement by health care professionals.

I was involved with this case primarily as a researcher but also as a fellow practitioner. I am a fellow practitioner in the sense that I am a mental health professional with whom the team identify and I am forming my own professional opinion but I am not involved in the clinical care. I interviewed Elsie on four

occasions through the course of a year. Her sister was present during the second of these interviews. Alongside this, I interviewed the professionals who became involved in Elsie's care. Firstly, this enabled me to have first hand experience of her, as she presented, and thereby to formulate my own professional judgements. Secondly, I spent time deliberating with the other practitioners involved from the EMH team about Elsie's case. Such deliberation, would occur in everyday practice albeit not to the same degree that the research interview permitted. These aspects mirrored my professional practice and enabled me to examine the process occurring, thereby giving me the opportunity to make parts of that process explicit that would normally be implicit. The difference between this and everyday practice is that these processes usually occur automatically, almost unnoticed, in the hustle and bustle of clinical life.

I will clarify my role in more detail because it has a profound effect on the study. I am not attempting to be detached and uninvolved, and therefore this is unusual within medical research. It is not possible to come into contact with a person without the ensuing interaction having an effect on that situation: to ignore those effects would present an incomplete picture. This is well recognised within qualitative research and indeed the researcher is the main research tool (Holloway and Wheeler 1996). In contrast to the randomised controlled trial where every attempt is made to eliminate any influence of the researcher, in qualitative research this is recognised and valued, and contributes to the data. However, I am not only a researcher but also a practitioner. The two cannot and must not be separated. I bring to this research my experience and expertise as a fellow practitioner and it is on that foundation that the team, who chose to become fellow researchers with me, accepts me.

The team and I entered into a reflective discussion on their practice and my practice, with reference to Elsie's case. It was as we took time to stop and consider that half-formed thoughts became clear, both in our own thinking and in discussion with one another. These thoughts were in the form of ideas, fleeting impressions, images, a sense of unease or hunches, to list a few examples, but usually in clinical practice they remain so. They are never allowed time to enter the consciousness and become open to scrutiny. These tacit thoughts, although hardly acknowledged in everyday practice, do influence our judgments. The reflective discussion between colleagues

who mutually enter into it allows these thoughts to surface. It has to be a joint venture and certainly cannot be imposed on someone. This illustrates why it was central to this study that the team became fellow researchers with me and knew that I was a fellow practitioner with whom discourse was possible. As the discussions took place, they focused on Elsie and also led to the examination of more general issues of clinical practice, both within this particular team and in similar teams. The discussions contributed to the exploration of my professional judgments related to this specific case and to my professional practice in general.

The theories and insights offered in this work must be viewed from the perspective of a practitioner considering their own practice. Consequently this thesis includes a large subjective component. This does not negate the value of the illumination it offers. Rather it demonstrates the value of reflection for the development of the practitioner's practice and to stimulate further debate.

Now that I have examined some of the general background aspects of this case, I proceed to look at this piece of professional practice itself in detail in order to outline my thinking processes as a practitioner.

REFERRAL

The Consultant was contacted by Elsie's GP to refer her to the team. She had become low and depressed again. He had already changed her antidepressant and her demands for his attention were escalating. At this stage, further information was available through her previous medical notes. Whenever a patient is referred to the EMH team, as much information as possible is collected about the case prior to seeing the person.

She had been involved with the team about 10 years earlier when she had a short inpatient admission to enable her to be withdrawn from benzodiazepines. These are tranquillisers, the best known being Valium, on which people can become dependent. During that admission it was recognised that there might be an underlying depression, and she commenced a small dose of antidepressant called Amitriptylline on which she remained. The medical notes indicate that problems within her marriage

were recognised at this time but were not addressed, presumably because she did not wish them to be. I am assuming this is the reason, because it was not explicit in the medical notes. In the intervening period, she had no further contact with the team as a patient. The previous year, she had been involved when her husband was referred with dementia accompanied by behavioural problems. This resulted in him being admitted to the inpatient unit and, on discharge, into residential care.

It is important to recognise the significant effect that previous encounters with the team, and healthcare professionals in general, have on your relationship with a patient even before they meet you. If these experiences have been favourable, it promotes a good working relationship; if they were negative then you may encounter many unexpected difficulties. It is necessary to be aware of these issues, even if you cannot address them directly, in order to try and alleviate the damage that has occurred. These issues can still inform the understanding of the practitioner and contribute to their professional judgements. This was referred to by many of my colleagues as 'the baggage they bring with them that needs unpacking before you begin'. Alongside this, the role of the patient's life history and their social/cultural background must not be ignored. Significant aspects of this will be revealed on the journey with Elsie.

Reflections

Even before there was any contact with Elsie, a picture was emerging of a lady who had longstanding difficulties. She had clearly managed to cope, albeit not perhaps in the most appropriate way, but she had functioned adequately and had not required ongoing input from health professionals. However, she was now presenting in crisis and was unable to continue on her journey without professional input. From the information available, this crisis was possibly related to her husband going into care but this would need further exploration.

Her GP told me that he felt the 'system' had failed Elsie a long time ago regarding her son who has learning difficulties. He also recognised the consequences of her abusive marriage but strongly felt it would be inappropriate to expect to rectify all of these, not least because he doubted that Elsie herself wished to address them. His

purpose, in referring her to the team, was to enable her to regain a level of functioning that was acceptable to her.

FIRST STEPS TOGETHER

On receipt of a referral, the EMH team discusses it at a weekly liaison meeting. This is a multidisciplinary meeting and has representatives from all of the professional groups. New referrals are discussed and allocated to one of the professionals, who then carries out an assessment and formulates a management plan. This is reported back to the team at the next meeting. In Elsie's case, it was felt that the initial assessment should be medical, and the Senior Registrar was allocated her case.

I interviewed Elsie a few days after her first meeting with the Senior Registrar and then arranged to see him to discuss his thoughts about this case.

Elsie's Story

Elsie was now in her 70s, living with her eldest son who had moderate learning difficulties and relied extensively on her. Understandably, she had always felt very responsible for him, further emphasised because of the stance her husband had taken throughout his life. He had arranged for their son to be put into an institution when he was six without consulting her. She had fought for many years with the help of her sister to have him released. This had caused her a lot of heartache and she related in minute detail to me these events and her feelings. In one instance she visited her son to find that his hair had been shaved off and was horrified that this had happened.

Throughout their married life, her husband was verbally and physically abusive to her. Over the last two years, he had developed dementia, which resulted in the accentuation of his unpleasant personality traits, something that I have frequently seen in practice. She described to me how this reached a crisis point when she returned home one day to find the house turned upside down, with much of the furniture destroyed. The GP was called, who quickly involved the Consultant Psychiatrist, and her husband was admitted to hospital and then placed in residential care.

Despite the abuse, she remained loyal to her husband. This was illustrated by the way she visited her husband with her eldest son regularly after he was placed in residential care. This loyalty came to an abrupt end, however, during one of these visits when he started swearing at their son, demanding to know why she bothered to bring him along. At this point Elsie left, vowing never to return unless he could be polite to him. When I met her six months later she had not seen him since.

Unfortunately this led to a rift with her younger son, who could not understand why she had taken this stance with his father. At the time of her referral, he was not speaking to his mother. It appeared that up until that time he had been very supportive of his mother, helping her refurbish her house after his father had spoilt it. Looking back over the time, Elsie was always at pains to emphasise how supportive he was to her, but this was always described in terms of practical support, never emotional support or understanding of how abusive his father had been. I think it may have felt as if her younger son was siding with her husband at this point, which was not something I felt she was able to look at. I sensed that she repeatedly emphasised how good her son was to her in order to convince both herself and us that he was supportive. As a practitioner I viewed this from a psychotherapeutic perspective and formed the view that she was giving a strong message, albeit largely unconscious, that this issue was far too painful for her to address it. Hence I did not ask her directly about it. This certainly mirrors the professional judgement I would have made in clinical practice, and it would have been unethical to ignore that and cause her distress to further the research.

She relied heavily on her sister who lived down the road from her, and it was noticeable that she would often convey her views by attributing them to her sister. Initially she would ensure her sister was present during consultations and appeared to need her there as a support, especially if she was feeling unsure of herself. The Community Nurse commented:

> 'It was like Elsie needed a back-up against us, or she needed some strength to help her put her point of view across to us, and I think the sister was this strength, and the sister has dropped back out of it in the

last few weeks, and my feeling is that she's satisfied that I've heard the right message.'

Interestingly, it was at the point that her sister was about to go away on holiday that Elsie was referred to the EMH team. Both myself and the other professionals involved wondered whether it was the threat of losing her sister's support that precipitated the crisis. The Senior Registrar summed this up:

'- she was very dependent on her sister and I think the original crisis arose when her sister was away from what I recall. Yes I think it's becoming increasingly apparent that she wants to be something she's not. And with the fractured wrist and her disabled son whom she feels very guilty about um from years gone by. I think we're going to have to start looking at how capable she is of even living alone. But I think it's going to be quite a journey.'

There was also an increasing awareness that Elsie was quite dependent although she saw herself as an independent person who was able to cope with most issues. I would suggest this view she had of herself was one reason why it was difficult for her to confront some of these underlying issues directly.

The Researcher's Initial Contact and Impressions

I met Elsie a few days after her first meeting with the Senior Registrar from the EMH team, having arranged an appointment with her by telephone. I arrived mid morning at the council estate where she lived in a terraced house, tucked away in a quiet cul-de-sac. I expected the interview to last about an hour and a half hour at the most, but in the end it was nearly two and a half hours long.

Elsie opened the door to me promptly. I was presented with a grey haired lady, of slight build, who had a worried expression on her face. She seemed to convey a sense of urgency.

Although she greeted me with the familiarity associated with a trusted friend, I was immediately aware of her deference to me as the doctor. I've noticed in my practice that older people often hold doctors in awe, almost on a pedestal. Personally, I find that quite uncomfortable, because immediately I am aware that they probably have an expectation that I am infallible and will come up with the longed for solutions. In fact, the longer I'm in practice, the more I am aware of my fallibility and the insolubility of many problems. By that I do not mean I cannot help, but the way I can help may be by being with them in the problem, rather than removing it. This is clearly seen when a person has dementia; I may be able to alleviate some of the distressing effects but I certainly can't make it go away. I only wish I could.

I felt disquieted by this almost over familiarity and, on reflection, I think this was for two reasons. My first concern was how vulnerable she might be to an unscrupulous person, which would have been a worry to me had she been my patient. The second reason related to my role as a researcher and whether she had fully understood that. Further discussions with her did allay that concern.

She ushered me into her sparsely furnished sitting room, and immediately it was as if there was an avalanche of emotions pouring out. She was so desperate to tell me every last detail of her story that I felt there was no space for me to introduce myself properly, or to get my bearings. Initially I felt overwhelmed and engulfed by these raw emotions, which were coupled with her desperation for me to sort it all out. This scenario is very common in my everyday practice - often I find that it is only when I literally get some physical space by leaving at the end of the interview that I am able to see the picture clearly. As the professional, I am able to put the situation aside, but for the family this isn't an option.

Reflections

In my everyday practice I often mull over a particular case until I feel I have a grasp of it, usually when I am doing something quite unrelated. In many instances I will end up thinking about it in a pictorial way and for me this is an important element and informs my professional judgements. It is therefore a valid component of this portrait.

As I considered the landscape at this point in Elsie's journey, it appeared to me that there were many dark storm clouds already overshadowing her. Her life, although difficult, had radically changed with the loss of her husband and the consequent loss of stability and predictability this gave. There was now a rift with her younger son on whom she had depended, especially when her husband became incapacitated. Other storm clouds were appearing ominously on the horizon, none of which she was able to exert any control over. She was growing older and frailer, her eldest son depended solely on her and there was no provision made for him should she become incapacitated or if she died. Perhaps the most terrifying aspect for her was the unchartered and exposed nature of this landscape that she had been ushered into by her circumstances, with no obvious shelter available to her. Indeed, the shelter she had relied on up until now, though far from ideal, had vanished in front of her eyes. Her husband's support was gone, her younger son was estranged from her, and her sister was about to go away on holiday. No wonder then, that she presented in chaos and panic, desperate for someone to hear her.

The Assessor's Perception

A week prior to my first interview, a senior doctor from the EMH team had assessed Elsie. He changed her antidepressant medication and arranged to see her again. When I met her she was distressed about the change in medication and was convinced that the tablets were making her worse. Elsie and her sister had become very worried when they read the leaflet accompanying the tablets. These leaflets have to describe every possible side effect no matter how unlikely it might be.

In the intervening week, she had her GP out on at least two occasions, and the antidepressants substituted with another alternative. She was equally convinced that these were doing her harm and what she really needed was her Amitriptylline back again. The request to be placed back on the original Amitriptylline was to become a recurrent theme for her.

In this situation as a practitioner, my first concern, like this doctor's, would have been to establish Elsie on an adequate dose of an antidepressant that she could

tolerate. Amitriptylline is one of the oldest antidepressants and often gives troublesome side-effects, some of which can be particularly hazardous in the elderly especially when higher doses are needed for it to be effective. Therefore, on this basis, doctors will try to use newer, better tolerated, and safer antidepressants in the elderly unless there is no choice.

Although to begin with, this looked like a typical case of agitated depression that should respond to treatment with an antidepressant, as our journey with Elsie progressed, the situation became far more complex. Here it is important for the reader to understand that, in viewing Elsie's situation this way, neither I nor the other professionals ignored the various issues involved or their significance for Elsie. Rather, the path that Elsie needed to take to regain her sense of well being wasn't quite the one we all expected from past experiences with similar patients. This illustrates how crucial it is to be able and willing to adapt to the individual's needs rather than rely on generalisations or procedures. Sometimes that means tolerating a period of uncertainty while the team aligns themselves to that individual. Certainly this is what appears to have occurred when initially it seemed that her messages to the professionals were getting lost. Yet it is far too simplistic to say that the professionals involved didn't comprehend the intricacies and complexities of her situation, both present and past. In fact, interviewing those involved, I was often amazed at the depth of insight and holistic understanding they showed of Elsie. Her CPN illustrated how she viewed things:

> 'You know when you look it's the pebble in the pond one, and it just kind of grows and it grows, and you think kind of 'wow'. You know the ripples are kind of endless for her. I think initially we were seeing it as an older lady who's got an agitated depression, and let's treat the agitated depression and everything else will be all right, but it just wasn't, something wasn't right in there for her.'

It certainly required time to reflect. The doctor commented that he hadn't rushed around to see Elsie on one occasion because he needed time to think. There is a sense in which professional practice just cannot be rushed to increase the throughput, as we seem to be constantly exhorted, if it is to remain professional. There is a real danger,

I believe, of undervaluing this essential component, and if it is lost we can end up with a 'cook book' replacement, which may on the surface appear adequate but will never truly fit the individual's needs.

To respond to an individual, the ability to 'listen' and use non-verbal communication is important. This was certainly true in Elsie's case and interestingly occurred both ways, from Elsie to the team and from the team to Elsie. Early on, it was decided that she needed admission to the acute assessment ward. The doctor's reasoning for this was both to establish her on an antidepressant but also to convey to her that, yes, we did take her seriously and that the professionals did care about her. He had picked up that she was angry and felt that neither he nor her GP had bothered about her in the preceding two weeks. She felt the tablets weren't working and she'd been left 'to rot'.

Reflections

The Senior Registrar had clearly made the diagnosis of an agitated depression but even from the first moments of his encounter was aware of all the other factors impinging on Elsie's life. Initially, he felt that treatment of the agitated depression would resolve the other problems. However, within a couple of days of meeting Elsie, he became aware of complicating factors, for instance her anger, and was reflecting on this in order to inform his management plan.

He was also very aware that, although there were many issues that could potentially be 'worked' on, such as the effects of her abusive marriage, Elsie might choose not to do so or might want to address them later. He talked about the need to be aware and sensitive to the person's own 'natural cadence', echoed in her GP's reflections.

Because they are quite tentative and largely implicit, these thought processes do not usually get recorded in the medical notes and are often not formally acknowledged by the team. These impressions, though, are often discussed informally by colleagues and seen as valuable by them. This does require time to talk together and sadly this is being seen as an unnecessary luxury, to be discouraged in favour of cramming more patient contact into the day. This work, however, is demonstrating just how essential this part of the process is to good professional practice.

PROGRESSION ON THE JOURNEY

Elsie was admitted to the inpatient unit which seemed to be an important turning point for her for several reasons. As well as her medication being reviewed and established at an adequate dose, she was in a caring environment. It is important not to underestimate the importance of care in the healing process, and especially so for Elsie, who had felt abandoned by the professionals involved. This came across as important when she told me how she felt understood as an individual by the nurses. She explained how all the staff were different and had different approaches with people but, in her words, 'All different, but it all merged in'. It was a recurrent theme, which emerged in our interviews together following her admissions. This emphasised the importance of feeling really understood as a basis to the sense of being cared for. It also conveyed the sense that for her the team at this point was functioning effectively as a whole.

Another factor for Elsie was being ill enough to warrant an admission. This legitimised her distress especially with family and friends. It was during this time that the rift with her younger son was healed and it may have needed this to facilitate it. This re-established an important support for her, or in terms of the earlier metaphor, a shelter from the storm.

After her first discharge, she fell and fractured her wrist. Unsurprisingly, her mood dipped following this and she was re-admitted. There were no major changes during this admission. She was cared for and given time. After some successful leave at home, she was discharged with community support in place. As with many patients, she was encouraged to phone the ward staff at anytime for support.

When people are admitted to the inpatient unit they are always assigned to a trained nurse, who becomes their key worker and oversees their care. This certainly doesn't mean that the other nurses aren't involved, but the key worker has prime responsibility for them, including reporting back on the weekly ward round. I discussed Elsie's care with her key worker and explored how she perceived her needs.

The key worker pointed out that by being with people so intensely and for prolonged periods of time, the inpatient staff are in a privileged position. They can observe the whole picture including the parts that can be well hidden in relatively brief encounters within the community setting. Sometimes, this is a strong argument for suggesting an inpatient admission when the professionals are not quite getting a grasp of all the aspects in a particular case.

It was also recognised that Elsie needed the intensity of the contact with the inpatient unit. This conveyed to her that her needs were being recognised and this then enabled her to start addressing them.

Key Worker's Reflections

The key worker saw Elsie's concerns about her eldest son as the major trigger for her illness. It was as if Elsie was trapped between recognising that she couldn't continue as his sole carer without increasing help and not wanting to relinquish this role. The key worker sensed that they both needed each other. Although Elsie was supporting her son, he equally was a 'sort of pillar' for her. There was a definite co-dependency. The first doctor who assessed her also spoke of their relationship being symbiotic. The importance of this may have been the key that was missing in the initial assessment that her CPN had commented on earlier.

Her key worker had grasped the conflicting emotions she was experiencing about her husband, both the intense anger about the abuse but also guilt feelings for not continuing to visit him. Her key worker felt this was easily hidden by the good front she was able to put on with people. However, careful observation by the staff revealed the true picture. She said in conversation about Elsie:

> 'Oh yes, you had to observe her. I mean they're very good, but if you look at them when they're not aware you are, they can appear quite sad sometimes. The eyes give it away as well; the laughter doesn't go up to the eyes. It might be on the face, but the eyes are quite sad.'

The non-verbal signals are essential, and sometimes give far more information than what is disclosed verbally. That doesn't necessarily mean patients are deliberately holding it back but they may not be aware of it themselves. These signals can also be very subtle and require experience to tune into them. Elsie's key worker referred to an instant with another patient:

> 'I can remember one patient and he just did something wrong by putting something on the trolley and it was so silly and I said to the staff would you take his temperature please. They were all looking at me because he was a Day Patient and they took his temperature and it was 38.5 and we had to admit him.'

This patient's acute illness could have been easily missed but an experienced nurse was able to read the situation and so he received appropriate and timely care.

Researcher's Reflections

Discussion with the professionals revealed they had a good grasp of her situation, but Elsie couldn't 'hear' that. She required the living out of her situation with the team to 'know' it was understood. It is not dissimilar to the situation frequently seen in psychodynamic psychotherapy whereby the work is done in the transference. This operates within the therapeutic relationship, using it to reflect and work on relationships outside the therapy setting. Sometimes experience cannot be replaced by anything else, even though this experience may require time and patience.

RESOLUTION – THE PARTING OF THE WAYS

Although Elsie was vastly improved following her admissions, there was still a lot of work for her to finish in the community. Returning to the metaphor of her journey, there was still a lot of ground for her to cover before she reached her destination. The end or destination is her choice not mine or any other professional. The destination will often be the same for both the patient and the professional but not invariably. It is vital as professionals that we remember this and don't try to impose our view of

'well being'. Sometimes it is quite clear-cut. For instance, a patient has a chest infection, and both he and his doctor aim to cure it. However, in psychiatry the situation is often less clear and certainly for Elsie, her perception of 'well being' was an important issue. This was recognised by all the professionals I talked to who were involved in her care. Her GP, whom I spoke to at the beginning, asked the team to enable Elsie to function effectively; he did not expect all the issues to be resolved, such as the effects of the abusive marriage.

After her discharge, there was a period of adjustment when Elsie appeared to be negotiating the rules of engagement with people, including her family. She frequently stated how important her boundaries were and for people to say to her 'would you like', rather than, 'you should'. Her key worker on the ward picked up quite clearly that it would be entirely Elsie's choice as to how much help she would accept with her older son, and if, as she put it, 'it didn't suit', then she would put a stop to it, no matter what anybody said.

When Elsie perceived the Social Worker from the EMH team overstepping the boundaries, she quickly and firmly addressed the issue. Elsie was finding finances very difficult, especially being able to budget for adequate heating, and without telling her, the Social Worker wrote to her younger son explaining this, asking him to help his mother out. When Elsie found out about this she was enraged and refused to have anything else to do with her.

Reflections

Interestingly, when I discussed the case with the Social Worker, she appeared to have a perceptive grasp of Elsie's needs and situation. Her description was of a frightened lady who presented with a huge gap between what she needed and what she could take on board. She felt strongly that it was important to get her trust and be able to support her by being there rather than by doing. It was obvious that she felt she had put a lot of effort in on a personal level, well beyond her role, to make what was available acceptable to her. She was clearly able to appreciate her many and varied needs, but I do wonder whether in her eagerness, and perhaps some desperation to help this lady, she ended up overlooking the importance of her

boundaries, especially in relation to her family. Whatever the reasons, ignoring the clear communication from Elsie to ask her what she wanted, resulted in the breakdown of their relationship. This then left no possibility of helping her in any way at all.

It is essential for professionals to work within the boundaries specified by the patient, and inherent in this is an appreciation of the patient's communication about their family and wider social culture. The CPN working with Elsie picked up the importance of keeping things within this family, as they did not like interference in their affairs and were very wary of people they saw as 'do gooders' who could impose things on them. Although this is the traditional role in which a Social Worker might be seen, and could therefore result in the relationship failing because of these preconceptions, I don't think this was the main reason in this case. There was also a Social Worker assigned to her son with learning disabilities, with whom Elsie developed a very good relationship. I think the relationship probably broke down because of the interaction and a lack of appreciation of these 'rules' within their family, rather than their preconceived ideas.

Although I have suggested the reasons above for the actions of the Social Worker I cannot discount an alternative view that encompasses a psychodynamic understanding of the operation within groups. The Social Worker may have subconsciously been confronting, on behalf of the team, the team's questioning as to how supportive Elsie' younger son was to his mother. The reaction this produced from Elsie would seem to confirm the team's decision not to address this directly.

The Last Few Steps Together

As time went on, the issue of becoming vulnerable with increasing age and worries about the future care of her disabled son emerged as central issues. They were in the background all the time, and often professionals involved would muse that these were probably the 'real' issues, and they came to the foreground as Elsie recovered. Initially, she started to allude to them in passing but in later interviews she was able to voice them:

> 'I used to agitate myself you know, about what will I do, you can't expect relations you know, J's 60 odd and my brother G he's 60, no 65, and my G and my daughter-in-law you can't expect them to do, it isn't fair. Oh yes, D was my bug bear.'

Reflections

Her needs for care were increasing as she got older. Previously the family had been able to meet them, but I sensed it was becoming too onerous for them. The outside help of professionals was needed but on Elsie's terms, fitting in with her family's way of operating. I wonder how much of that was 'known' to Elsie. There were no words spoken between Elsie and her family as far as I am aware. This awareness of these issues at some level by Elsie may have led to the state of panic in which she first presented.

LOOKING BACK

Reflecting on Elsie's journey with the EMH team, it was a 'successful' journey from a practitioner's viewpoint. She was enabled to return to an appropriate level of functioning to resume her life.

During her first meeting with me she said that all she wanted was her 'old Amitriptylline' back, and in the end she was put back on it, at the original dose, and became well again. To me, that was a symbol of her life returning to an order that made sense to her. Her relationship was restored with her younger son, and she was getting help with her older son and emotional support for herself. Using the analogy I employed before, some of the dark clouds had been blown away and some places of refuge from the storms were established for her.

However, what happened was totally illogical from a scientific/biological point of view. She had relapsed on exactly the same dose of Amitriptylline that she now became well on. Evidence-based medicine, as it is currently defined, dictates that the doctor must either increase the dose or explore alternatives. Maybe there are other aspects to the healing process that are in danger of being overlooked and under rated

by the very narrow focus encouraged by the current fervour for evidence-based medicine and protocols. The healing process was embarking on the journey with this lady, and my interviews with the team demonstrated this. It often meant being in the swampy lowlands (Schon 1983), and scrabbling up steep hills, not being sure of the correct path but we got there together in the end.

CHAPTER 3: CRITICAL APPRECIATION OF THE PORTRAIT

INTRODUCTION

I have completed the portrait of professional practice of one patient's journey with this EMH team during an episode of acute distress. I am now going to examine that portrait in some detail. This is to reveal some of the hidden or partially visible aspects within it that were influencing that piece of practice, but it also has relevance in the wider arena of professional practice. This is the critical appreciation in reference to the artistic/holistic paradigm (Fish 1998). This framework releases me, as the researcher/practitioner, to examine this portrait from as many perspectives or 'angles' as possible to contribute to the understanding of practice. It also fosters a holistic view of practice and acknowledges those aspects of it that cannot be given 'voice' in the conventional ways.

I start with some reflections on the whole portrait and the process of producing it. Following this, I examine some of the specific topics concerning professional practice that arise from the portrait and then conclude with an overview to integrate all of these aspects.

In the examination of this portrait I am not analysing it in the sense of reducing it to small, disjointed pieces to be further dissected. Rather, I am oscillating from close-up views to more distant views, in the same manner as a camera lens, but maintaining throughout the wholeness of the portrait. This is central to the holistic aspect I seek in this work. I would emphasise again that this is a reflection by a practitioner from the position of practice. Through this I aim to explore and further my own and fellow practitioners' practice. I am not seeking to undertake a complete and exhaustive study in the same way an academic might undertake a critical review of the literature on a particular theme. I consider observations from my own and others' practice, including the portrait of practice undertaken. The portrait in this instance could be seen as the springboard to facilitate the ensuing reflections. These reflections grow and incorporate other instances and thoughts from years of practice, many of which have lain dormant until now.

The literature is used to begin critically explore the ideas that emerge from this process. At this juncture, the exercise is not about carrying out an extensive search to critically appraise the available literature. This is something I may wish to undertake as a practitioner at a later date. I feel this process needs to be highlighted because the subtle differences in the way that the literature is used could cause confusion for my readers if I did not make it explicit. As the research progressed, I became more aware and able to verbalise these differences. Indeed, one of the reasons I believe that practitioners often avoid reflecting on their practice is because they believe that the only way to do this is to carry out a literature search, and then critically appraise all the literature available. This is the method adhered to in the evidence-based journal clubs and case conferences, which are now seen as the gold standard for medical education. As a practitioner I have attended many of these, and I do not think I have ever come out truly feeling that my practice has been enriched. However, when I have been involved in 'old fashioned' case discussions that frequently revolve around a dilemma but with no hard answers in the literature, then I come away feeling that my practice has grown. In these instances, literature may indeed be drawn on to illuminate an aspect or stimulate further reflections. This is how I use literature within this part of the reflection. These issues will be further explored in chapter seven.

THEORIES IN PRACTICE

A recurrent theme in much of the recent literature is the need to elicit the personal knowledge or theories that we use within our practice. These are not the same as the public theories we know and that form the knowledge base of our professional discipline. Neither are they our espoused theories, the ones we would say we based our practice on if asked. Rather, these are the theories, or constructs, out of which our practice flows but often remain hidden even to ourselves. Yet these theories are the mainstay of everyday practice and there is a need for practitioners to become aware of them in order to critically examine them. Many writers (Cervero 1992; Coles 1996; Day 1993; Eraut 1994; Schon 1992) see this as the purpose of reflection and is an area I return to later. Therefore, before rushing to examine some of the issues about professional practice that are evident to me in the portrait, I have sought to

reflect on the possible theories operating within my own and my fellow practitioners' practice.

The Holistic Perspective

It is significant that when I started to draft sketches for the portrait, I initially wrote it as Elsie's story and journey. It wasn't until I was questioned as to the purpose of the portrait, whether it was to illustrate a piece of professional practice or whether the focus was on Elsie's experience, that I began to perceive the differences. This resulted in me subtly, but nonetheless significantly, revising the presentation so that it proceeds chronologically as the piece of practice unfolds. I have attempted to enable the reader to view the events through my eyes. In this way I hope to foster an insight into the experience of one professional as she sought to think through and make judgements in a changing and evolving situation.

It is not, I think, insignificant that I encountered this difficulty. I would suggest it reflects the thinking within this team, whereby they endeavour to synthesise a picture of the whole person. The focus is on patients and understanding them, and the 'picture' will undergo possibly countless modifications. However, it maintains a holistic view and the underlying processes involved to generate this are often lost to awareness. In the same way, in writing the portrait I had to step aside from the final picture and consciously redirect my area of focus. There is also a need to step aside from the practice to consider how a holistic view was fostered.

Even before contact is made with the patient, there is an acceptance that it is important to gather as much information as possible. It is only in situations of urgency when this would be temporarily dispensed with. This involves accessing any previous medical records and finding out if the patient was known by members of the team in the past. This is an unspoken rule within the team, upheld especially by the secretaries who actively seek out this information if it is not available at the time of referral.

Prior to Elsie being seen, much information was already known. There were details of her past involvement with the team when she was addicted to benzodiazepines,

and of the difficulties in her marriage. Recent developments resulting in her husband's placement in residential care appeared to have triggered the crisis. A provisional diagnosis was suggested from the GP's referral, which described her as depressed and agitated. All of this was gleaned even before meeting her.

The reflections within the portrait demonstrate how Elsie's story was beginning to be 'told' by the professionals, though it was acknowledged that it was only the briefest of outlines. However, looking at the professional practice, this is an important stage and certainly occurs in the majority of cases. It also occurs within practice in a wider context. Even in busy medical outpatients, the doctor will read the referral before the consultation and will have formed some concept of the issues. This is an indispensable part of the process and is emphasised by the high levels of tension generated when referral letters are mislaid or previous medical notes are unavailable.

There appear to me, to be at least two processes at this stage. One is the provisional assignment of a category or schemata to the problems presented. In medical terms, this might be a possible diagnosis, which in Elsie's case was an agitated depression. There has been extensive work looking at the cognitive processes within clinical reasoning and the use of categories (Hayes & Adams 2000; Eraut 1994; Schmidt et al. 1990).

The other process relates to the patient's narrative or life story and begins to place the episode of illness in context. Even though the person can be placed in a probable category of illness, it will remain, I believe, a unique experience for this individual and must be recognised as such by the health professionals involved. As Bochner (1997) points out, we are the stories we live, and it's by the medium of telling that story that we convey who we are. The illness narrative is embedded in the narrative of an individual's life and cannot be fully comprehended in isolation. Kleinman (1988) looks in detail at the illness narratives and their effects on his patients' lives, conveying the interdependence of the two. His work highlighted the importance of this aspect within the medical profession.

These two processes are both inherent in the practice but at opposite poles; the first towards generalisation and the second towards individualisation, each occurring simultaneously. Brody eloquently states this:

> as the physician is always caught in the tension between the uniqueness of the individual patient and the need to explain the patient's illness by means of generally applicable laws.
> (Brody 1987, p.17)

Both aspects are important in developing the holistic view sought in practice; either one alone would be insufficient.

Another aspect within the portrait contributing to the holistic view, was the use of visual imagery closely intertwined with the use of metaphors. Practitioners used them to explain and communicate the whole picture to themselves and to each other. Indeed, as I wrote and reflected on practice, I employed the metaphor of a journey representing Elsie's life. We, the professionals, were invited to walk with her for a time but it remained her journey. This is the way I construct the picture I have of my practice as a psychiatrist: being invited to join people on their unique and personal journey. Alongside the metaphor of Elsie's journey I constructed a visual image of the landscape that confronted her. This enabled me to convey the whole picture in a way that encompassed deeper levels and insights that no amount of words could do. Atkinson (2000) comments that the use of vision occurs typically when the practitioner is operating at a holistic level. When discussing a patient with a nurse therapist, the latter said to me, 'She's like a frightened rabbit'. A wealth of understanding was conveyed to me by that comment and it made sense of some of the puzzling aspects within that particular case.

To build up this picture or 'feel' for Elsie required time to reflect or mull things over; without this a holistic picture cannot be gained. The Senior Registrar chose not to respond to the demands of the patient in order to grasp the dynamics of the situation, and thereby meet her needs fully. It is possible that, had he responded to the immediate demands made of him, his clinical judgment may have appeared praiseworthy because of a quick response to a consumer's right, but in the longer

term may have been ill formed and found wanting in terms of the patient's welfare. There are many pressures on professionals to act speedily, and anything less is seen as wasting time or inefficient. In fact, the contrary is true: efficiency comes with time given for reflection because this enables the holistic view, which in turn leads to sound, effective clinical judgments.

In his discussion of the role of reflection in professional practice, Day (1993) emphasises the need for time to allow this to take place and, just as crucially, for it to be promoted and valued by the organisation. Sadly, neither of these ingredients appears to be included in the modern climate of health care.

Claxton (2000) analyses the anatomy of intuition and cites rumination, 'the process of chewing the cud of experience in order to extract its meaning and its implications' (p. 40), as one important aspect closely allied to the processes of creativity and problem solving. This closely links into the ability to hear the unspoken, emphasised by both the Senior Registrar and the key worker as having impacted on their overall view of the situation and informing their clinical judgments. Interestingly, although both describe the same function, their own rationale and view of it differed and appeared related to their own experiences of professionalism. The key worker spoke of it as an integral part of practice that comes with experience, with an almost 'common sense' feel to it, whereas the Senior Registrar viewed it as arising from his specific training in psychotherapy, although applying it in a wider clinical context. This illustrates how our own personal histories and the professional culture we develop within continue to inform our view of practice. Pietroni (1992) reminds us of the languages that the different professions use and how failure to acknowledge this can lead to fundamental breakdown of communication. This was not a problem in this case but cannot be overlooked even in teams that appear to function well at a multidisciplinary level. Returning to hearing the unspoken, this is another aspect of information gathering that starts at the moment of referral, even prior to meeting the patient, and continues throughout the whole episode.

As well as each professional building up a picture of the situation, there is a corporate picture formed through discussions between colleagues, both formally and informally. Practitioners bring their information, with their interpretation and insights

into it, entering into a process of mutual reflection and reframing, ending with an agreed modified narrative that could undergo many more reformulations. The process may never be complete as it can only ever be just a shared part of one person's personal and unique narrative. The telling of the joint narrative, however, does not occur only with the professionals but also with the patient. The very process of telling and retelling it with possible modifications can be an important element in the healing process. This crucial aspect will be discussed further later in this chapter. For the purpose of considering the attainment of a holistic view, the act of joint storytelling is an important building block, though I wonder how often it is recognised and valued in everyday practice.

In summary, some of the theories-in-use evident to me within this piece of practice that relate to the holistic perspective and individual understanding of the patient's needs are as follows:

1) A holistic, patient-centred focus is the goal sought by the team;
2) Information gathering is a central and ongoing feature;
3) A full appreciation of the context is sought and is one of the goals of the information gathering;
4) Non-verbal information is valued and utilised;
5) Reflection and mulling over of the case facilitates a holistic view;
6) Time is needed to think about cases;
7) Visual imagery and metaphors are used to facilitate individual practitioners' understanding and the communication of this to other practitioners and sometimes patients as well;
8) The construction of a joint narrative between practitioners and patients is negotiated and ongoing.

Uncertainty

Another major theme that impacted me within this piece of practice is uncertainty; not always knowing all the facts or answers. This was central in Elsie's case in the way all the professionals put forward suggestions, right up to the end, concerning the major issues for this woman and her distress. It appears that the crucial issues for

Elsie were concerns about her son with learning difficulties and her realisation that she was growing older. She was able to verbalise some of this at the end, giving weight to the professionals' thoughts, but it remains a suggestion or hypothesis as it cannot be proved beyond doubt. Yet, if the professionals had not attempted to understand these issues and had not tolerated not knowing for sure, Elsie's healing process would have been prevented. It was essential for her to sense that the team comprehended her distress and its causes, despite her inability to verbalise it to herself or to them.

There are also times when the practitioner will choose to accept uncertainties. In considering Elsie's case, I suggested that it might have seemed that her younger son was siding with her husband. Indeed, I wondered if he had given emotional support to her at all because of a possible lack of understanding of the abuse his father had inflicted on his mother. However, I made the conscious decision not to explore these issues with her because I felt it would be non-therapeutic and possibly even counter therapeutic for her. In this instance, therefore, it was a professional judgment to 'live' with this uncertainty. It was the best fit possible with the information available, combined with insights gained along the way. Nevertheless, there remains an element of uncertainty. This is inevitable when you are involved in complex human situations. Professional practice is far more than the assignment of a diagnosis and the prescription of a treatment regime. We are seeking to comprehend the individual's experience of illness, which is their lived experience and ultimately only they 'know' this.

> …we need physicians who are able to acknowledge uncertainty. Doctors will be able to do this better if they recognize uncertainty to be not a technological failure caused by limitations in their knowledge or skill in applying it, but rather a ubiquitous element of the inherently interpersonal, context-specific, and judgement-dependent nature of the practice of medicine.
> (Charles 2001, p.62, quoting Beresford 1991)

It seems to me, however, that uncertainty is something we find very uncomfortable both as human beings and as professionals. Patients look to us to bring certainty and

control back to their lives, seeking the professionals' help during times of intense anxiety. They come to us with unexplained symptoms that may disrupt their lives permanently or even herald their death. We respond both as human beings who recognise this anxiety and as professionals trained to 'have the solution'. There are therefore two expectations for certainty pressing in on the professional: their own and those of the patient. Mullavey-O'Byrne and West (2001) suggest that problems arise from expectations not being met rather than resulting from the unexpected.

Therefore, to admit uncertainty either to the patient or ourselves can cause high levels of tension because a deeply held expectation is not fulfilled. It is not surprising then that this is an aspect of practice we would prefer not to acknowledge.

In addition to the pressure from these inherent expectations within the encounter of patient and professional, there appears to me from my perspective as a practising psychiatrist, to be increasing demands for certainty from the evidence-based medicine movement. This certainty is portrayed as achievable, which results in a perception that practitioners either lack the skills or commitment to practise evidence-based medicine in its current form (Turner 1996). This has fostered a culture, especially within medicine, whereby it is perceived as a weakness to admit uncertainty. Charles highlights Beresford's argument that:

> knowledge uncertainty is only one type and by no means the most important type, of uncertainty faced by physicians in treatment decision making. Uncertainty, he argues, is a fundamental and inherent characteristic of the decision-making process.
> (Charles 2001, p.66)

Alongside this, the patient has been encouraged by recent political ideologies in many of the western countries to view themselves as consumers with the accompanying rights that go with this. This includes the right to a specified product that should attain to certain expected standards otherwise compensation can be sought. Mullavey-O'Byrne and West (2001) describe this situation in the context of health care in Australia but they could just as easily be describing the United Kingdom.

Clearly, uncertainty is inevitable within professional practice and needs to be tolerated but, because of pressures within the practitioner and without, is difficult to acknowledge. In fact, in the current climate, it can require a lot of courage to do so. Some of the theories in practice from my perspective relating to uncertainty within this portrait were as follows:

1) Uncertainty is an everyday part of practice;
2) It is important to tolerate not knowing and to avoid prematurely making assumptions to alleviate the accompanying anxiety;
3) To accept that some aspects can never be known for sure;
4) Sometimes it is appropriate to decide to live with uncertainties in the patient's best interests.

The Processes of Communication

Communication was a key issue for Elsie's well being. I would suggest her 'healing' occurred at the point when she felt understood and when this had been conveyed to her. The role of antidepressants was, in her case, scientifically irrelevant for the reasons I explained in the portrait, but they were part of the communication process. It is recognised within psychotherapy that the use, or not, of medication can be a means of communication with the patient quite separate from the biological action (Dewan 1992; Sarwer-Foner 1993). Of course, the two roles are not mutually exclusive (Paykel 1995). However, in Elsie's case I sensed it was the former role, as a means of communication, that was predominant. Giving back her Amitriptylline symbolised the regaining of her sense of well being in her illness narrative. Verbal communication is important but in Elsie's case the use of non-verbal communication, both from her and to her, were central. This highlights its importance in the general arena of professional practice, even though at times its use may not be so obviously important as it was for Elsie.

There were several areas in which these aspects were illustrated in the portrait. Messages were conveyed to the team through Elsie's actions, for instance in needing her sister present during initial contacts, and the significance of this was appreciated by her CPN. Likewise, actions by the professionals were important messengers to

Elsie: the decision to admit her was clearly taken to convey to her that the professionals involved had not abandoned her in her distress. In this instance, words or verbal messages were unable to communicate this to Elsie; it required a 'lived experience'. She needed to experience the care in a practical way. I suspect that had this not been 'heard' by the team then the outcome for Elsie might have been very different. The ability to understand that an admission meant 'being cared for' for her was paramount. For another person it could have been the exact opposite and meant failure. There is a sense that, as professionals, we need to stand in other people's shoes and be able to view things from their perspective.

It would be easy to say that to appreciate a patient's perspective you just need to ask about it. This is advocated in the consumer view of health care. This portrait emphasises how important the unspoken elements were to gaining insight into Elsie's world view, without which her needs could not be addressed. One argument could be that if she was given the opportunity, she would have verbalised these aspects. I would disagree with this assumption for two reasons. Firstly, to facilitate her ability to recognise and verbalise some aspects of her story required that they were first heard by the team. This meant being sensitive to those non-verbal messages. In Elsie's case, the team began to feel, as they worked with her, that the real issue revolved around growing frailer and her worries about her older son with learning difficulties. It was only at the end that she began to tentatively put some of this into words, although even then not directly but mentioning it in passing. Secondly, and not just in psychiatry, there will always be aspects operating within the therapeutic alliance that are unconscious and may, for various reasons, not be available consciously. These elements are extremely important, especially in the most complex situations. If they are not available to the consciousness they cannot be directly verbalised and will be communicated in a non-direct way (Balint 1957). This is certainly an area in which the 'patient's baggage they bring with them' will be relevant. Transference is:

> 'the phenomenon whereby we unconsciously transfer feelings and attitudes from a person or situation in the past to a person or situation in the present. The process is at least partly inappropriate to the present.'

(Hughes and Kerr 2000, p.59)

It is an area all professionals need to be aware of otherwise important communications will be missed or distorted. Because Elsie's younger son was only able to give his mother practical support in a caring relationship, and not able to discuss feelings, maybe this was why she needed the practical expression of care through her admission. The interaction mirrored her experience of care with her younger son. Even though I suspect it was far from ideal, this was possibly the only 'caring' relationship she had experienced.

In Elsie's case, and not uncommon in other cases, was the use of various aspects of communication to address issues without directly discussing them. Simply giving a person the space and security may enable these issues to be resolved without them being openly named and 'worked on'. In one instance, when interviewing another patient on several occasions during the research, I was aware at the end that she had used those sessions to come to terms with the loss of her husband, although when asked directly, by myself or the other professionals involved, she adamantly denied having any difficulties coming to terms with the loss. Her comment during our last interview was:

> 'Well I knew he wasn't as fit as he should be but we sort of worked around that it was his heart you know, it wasn't as good as it should be. But the doctor in L. was very kind to him, on the usual tablets and that sort of thing. I suppose it was a little bit of a shock when it happened but then if I could have chosen I would have chosen he go first because I think I ----- There, I thought I could cope perhaps I couldn't.'

This comment at the end was the closest she came to acknowledging the difficulty she experienced following her husband's death. Up to this point with myself and the other professionals involved she insisted she had coped well and this wasn't an issue for her. Undoubtedly, acknowledging her grief was seen as a weakness within her family but she had addressed her grief without acknowledging it directly.

Alongside this issue there are some aspects the patient will choose consciously or unconsciously not to address, and it is important not to impose our own agenda as professionals. It is important as well to be sensitive to their timing or, as the Senior Registrar described, be sensitive to their own cadence. He initially felt that treating the agitated depression was the first issue and then the other issues would be addressed. However, it transpired that Elsie's cadence was the other way round and the team had to align with that.

One area that is easily overlooked in professional practice is the role of discourse in which all our communication is embedded. By discourse I mean the assumptions we have about how the world should be, our social practices and conventions, and expectations of what will occur (Horsfall et al. 2001). This governs how we relate to each other and therefore what and how we communicate. I sensed on meeting Elsie a marked deference towards me as the doctor. As I pointed out in the portrait, this is not unusual especially with some elderly people. The expectations of the role of the doctor and patient immediately govern our interaction, even before either utters a word. The Senior Registrar spoke at length about the different information patients will share with different professionals. Doctors are privileged by the way intimate and sometimes embarrassing facts are disclosed to them without any prior relationship having existed, whereas there are other aspects that patients wouldn't dream of telling the doctor but would be willing and expecting to disclose to the nurse. I'm not suggesting that it is necessarily wrong but rather we should be aware of the role of discourse in all our communications both with the patients and with each other. There may indeed be times when we need to be willing to challenge it.

Theories of communication that have emerged as I considered my practice are:

1) There are many different forms of communication in practice;
2) Medication can have a symbolic meaning that will influence the communication;
3) Non-verbal communication is a major component of all professional practice;
4) Issues can be addressed and resolved without naming them directly;

5) The relationship between professional and patient is a key element in communication;
6) The patient's timing must direct the course of communication and the content;
7) Awareness of the effect of social convention in the patient-professional communication needs to be fostered and challenged if a hindrance.

ASPECTS OF PROFESSIONAL PRACTICE

There were several topics relating to professional practice in general that arose for me within the portrait and during its creation. I will now turn to reflect on these in more detail. The topics I will be considering are:

- Reflective practice;
- The healing process;
- Doctor-patient relationship.

An important point that I feel must be re-iterated again as I turn to discuss these topics is that these are my personal reflections and I am not claiming that they are universal truths. The views I put forward are my own and arise from a practitioner reflecting on her own practice. I do not suggest that the literature cited is exhaustive; this is not a literature review of these topics, rather the literature supports the reflective process.

Reflective Practice

In the process of creating this portrait I was aware of the large amount of reflection it entailed. This was evident in my own deliberations as I sought to fully grasp the issues, and in my discussion with the other professionals involved in Elsie's care. This prompted me to consider what is meant by reflective practice.

One of the problems I am aware of as a clinician concerning reflective practice is that it has become a 'buzz word', and there is a real danger that everyone has heard about it but no-one agrees as to what it really means. I have heard it used in a wide variety of contexts within health care, ranging from stopping to think about what the professional is doing, to a form of quite formal clinical supervision. The danger then arises that people will become confused and disillusioned with the concept, resulting in the opponents of such 'soft' alternatives to evidence-based practice gaining effective ammunition.

As I began to consider the concept in relation to this piece of practice and the subsequent exploration of it, I became aware that it is not just one concept but several. We need to be clear in our thinking and discussions exactly what we are referring to. One aspect that was very evident in the clinical practice was reflection by practitioners, both individually and together, as they grappled to fully understand Elsie. The literature does not seem to refer to this type of reflection. There is also reflection on the process of the practice to elicit the theories in use and aspects of professional practice. This is more embedded within the research process itself and more aligned to the literature (Amies and Weir 2001; Boud et al. 1985; Cervero 1992; Coles 1996; Day 1993; Eraut 1994).

However, the reflective process that occurred within the practice itself stood out as a central part of that practice. For that reason, I am going to spend some time exploring this and I would argue this reflection is an important component of deliberative judgement (Fish and Coles 1998, pp.254-286). The portrait of practice demonstrates how my reflections were central to the professional judgements I formed. I will be looking in detail at reflection on practice within the chapter on professional practice.

Reflection inherent in practice

This occurred spontaneously and naturally during the research interviews. While I was conducting these, I had a sense that we were engaging well in reflective practice. It was only later as I grappled to make sense of the material and align the data to the research aims that I grasped the distinction between what I, and I think the team,

ascribed as reflective practice and the more prevalent or accepted view of this within the research community at large. The process of examining the theories underpinning practice did occur but with considerably more effort and not spontaneously. Indeed, reflecting on the research process now, had I fully understood this distinction then, I may have pursued more vigorously the alternative form of reflection at that time.

Initially, this realisation caused me a lot of anxiety and I wondered whether it would invalidate my work. I would argue, however, that it doesn't, but actually gives valuable insights into the working of this particular team, which I would suggest are mirrored in other teams. It highlights an important area of reflective practice that has not been recognised as such or valued for the role it fulfils. This is central to deliberative judgement, which Fish and Coles (1998, pp. 254-286) argue is fundamental to professional practice. The fact that it occurred so naturally and spontaneously when interviewing members of the EMH team is indicative of how well developed it is within this team and their everyday way of working. It required little or no facilitation by the researcher but just happened once space or time was made available.

It was evident that the professionals valued reflective practice. One of the Community Nurses, while discussing another patient with me, used the interview to reflect and clarify her reasoning for adopting a particular approach with a patient. Her 'gut reaction' was that this was the best way forward with him but couldn't say exactly why she knew that. At the end of our interview she stated how good it had been to have the time to think about this case and to confirm that her 'hunches' were correct. This became clear to her as she considered some of his life experiences and what their impact might have been on him. A few years earlier, up until her death, the team had known his wife when she was diagnosed with Alzheimer's disease.

Understandably this had been a distressing time for him and contributed to him finding it difficult to engage with the team when he became depressed. His Community Nurse was aware of this and had also sensed his inability to allow an 'official' diagnosis of mental illness to be given. However, he was keen to have her support on his terms. Because she was sensitive to his boundaries and able to pick up many of his unspoken messages, the interaction was successful.

Turning to the reflective process itself, I would suggest it fulfils several functions, all of which are inter-related and often inter-dependent. One of these, as discussed earlier, is to promote the holistic view of the patient. This requires time to ponder or mull over the case. Claxton (2000) aptly names this rumination. Rumination is closely linked with intuitive thinking which allows all forms of cognition to operate and complement rational thought. These other forms of cognition include the aesthetic and emotional. This aspect of the reflective process allows all these elements to play a part in informing the practitioner. At this juncture, practitioners may become aware of the significance of 'hunches' and fleeting impressions that so often they are aware of within the clinical encounter but cannot immediately process consciously. Likewise, for the Community Nurse in the example above, she was able to process these factors when given the opportunity for reflection. In this context, the use of metaphors and visual imagery should not be overlooked as was demonstrated in the picture I formed of Elsie's journey.

An apt description I think, of this form of reflection is the application of a 'perceptive, ruminative and inquisitive attitude to one's own perceptions and reactions' (Claxton 2000, p. 50). It enables the narrative to develop. Otherwise, the individuality of that person would be lost and from their perspective the significance of the illness would be lacking. It allows for subtleties within that person's story to be appreciated, often conveying the essence of their uniqueness. It places the person and situation in context: they are no longer the case with the agitated depression; they now have a face that you can see.

Reflection in practice can be a means to understanding levels of communication that cannot be fully expressed verbally. For example, the messages conveyed in the transference may hold the key required by the practitioner to unlock a situation. Elsie's key nurse astutely recognised the non-verbal signals. In achieving this, it opens the way for empathy to develop and this may be the vital ingredient for patients to experience 'being heard'. Looking back, with Elsie there came a point where she seemed to sense that the team understood her and she was then able to move forward. Maybe this was the point at which empathy came into operation. Heath talks of bodily empathy:

This is the ability to identify imaginatively with the patient's subjective experience of illness to provide genuine recognition and validation of that experience. Only if the patient can believe that their experience is understood at a fundamental level by the doctor will that patient be able to trust in the doctor's interpretation of their illness.' (Heath 1995, p.28)

In considering my own experiences as a patient, there are definite times when I sensed a 'real' understanding and that in itself brings a sense of healing. The words said or the facts conveyed may have been virtually identical but there was a vast difference in communication.

It is important not to overlook the role this aspect of reflection plays in the diagnostic and decision making process for the appropriate treatment plan. Undoubtedly this does link into evidence-based medicine and the practitioner accessing their propositional knowledge. It may lead to actively searching out further aspects of this when not readily available to the practitioner. Ultimately, as stressed by many authors (Sackett et al. 1996; Sullivan and Macnaughton 1996; Greenhalgh and Hurwitz 1998; Downie and Macnaughton 2000), propositional knowledge then has to be connected to the particular patient in question.

All of these aspects together promote a greater depth of understanding of the patient's lived experience that can be flexible as the illness evolves, centred on the person's uniqueness and individuality, and informing professional practice. I would suggest this is the key element that takes it from the cold clinical encounter concentrating on technical issues to the warm caring encounter concentrating on the human distress.

This element of reflective practice, or deliberative judgement, is closely related to reflection on practice and at times the boundaries blur. The focus is slightly different; deliberative judgement is concentrated on patients primarily to gain an understanding of them, whereas the latter focuses on practice itself, primarily to develop it. It requires a subtle but nonetheless real shift in the gaze of the practitioner. There is a valid argument that these two forms should be seen quite separately and both valued in their own right. As I stated earlier I do not think this form of reflective practice,

inherent in the clinical encounter, has been fully acknowledged. Maybe the term reflective inquiry should be adopted. The closest reference to this aspect of reflective practice is in Higgs and Jones' discussion of clinical reasoning:

> Clinical reasoning was described as a process of reflective inquiry, involving the client if possible, which seeks to promote a deep and contextually relevant understanding of the clinical problem, in order to provide a sound basis for clinical intervention.
> (Higgs and Jones 2000, p.10)

I would suggest that this reflective inquiry is the conversation with the situation described by Schon (1991), which he examined in detail with reference to the architect and used an example from a design studio. In the same way the health professionals allow Elsie's situation to talk to them, they then talk back to it with their reflections and it answers, and so the conversation proceeds. This conversation is the reflection in action that Schon cites that can so often proceed almost automatically and go unheard in the practitioner's life. However, I believe, it is time for it to be clearly heard and appreciated for its central role in professional expertise.

Eraut (1995), in critiquing Schon's epistemology of professional practice in which the concept of reflection in action was presented, argues strongly that it was only partially formulated because his emphasis was on developing a strong argument to counter the dominant technical-rational view. Although this purpose was well accomplished, and perhaps the main spearhead leading to a re-evaluation of professional practice, it did leave some of the concepts he introduced under developed. One of these concepts is reflection in action, closely linked with knowing in action. The boundary between the two and their distinction is not entirely clear. In Schon's discussion, I would agree with Eraut's suggestion that the implication is that reflection in action is a knowledge-creating process which occurs when novel situations are encountered that cause the practitioner to step aside, perhaps only for a moment, from practice. I would contend that this reflection in action can occur at many different levels: it can be entirely intuitive and on-the-spot or take a more conscious and deliberative stance when thinking over the case in question.

The pressure of work may govern this reflection at times. When faced by an overbooked outpatient clinic, decisions are demanded of the clinician. There is no time to think and the practitioner just hopes to have made the right choices and that instincts and well rehearsed routines were correct. I am aware at times of feeling dissatisfied when I am forced into working like this because I do not sense I have given the best quality service to patients. There is a sense in which they become the agitated depression that needs treatment, rather than the person who happens to have a depression. The crucial element here is the reflection in action that facilitates the appreciation of the person and the uniqueness of this experience to them. It allows the practitioner to create a unique solution, not necessarily a cure, for them, which is when artistry begins operating.

Even in these pressurised situations you can find yourself thinking over, or reflecting, on some aspect or choice facing you, even if it is only fleetingly, and does suggest that this process of reflection in action can occur quickly and at a subconscious level. That is why I am not always dissatisfied when working in time pressurised situations. The difference is I believe my knowing as a practitioner when I have really engaged with a patient and that artistry was involved, and when it was just a technical encounter.

The reflection in action may also occur later and at quite unrelated times. As practitioners, we quite often work with patients over a period of time, as this gives the opportunity to ponder on things in between face-to-face contacts. This can happen deliberately by the practitioner, or when they are doing something else quite unrelated. For me personally this often takes place spontaneously as I drive home in the evening when I'm not aware of particularly thinking about that situation. Again, as demonstrated in Elsie's case, the reflections need not be focused on a purely rational thinking process but can incorporate all forms of knowledge and varied forms of expression such as metaphors or visual imagery.

Eraut (1995) debates whether the processes that do not occur in the immediacy of action can truly be called reflection *in* action but would be more aptly labelled reflection *for* action. This would still distinguish them from the reflection focused on the process of the practice itself. Indeed, it could be argued that the process I am

describing here is a metacognitive process, alluded to by Eraut (1995) in his critique of Schon. This would certainly relate back to the description of reflective inquiry in relation to clinical reasoning given by Higgs and Jones (2000). It must, however, acknowledge all forms of knowledge, including the technical aspects, that inform the practitioner.

This aspect of reflection that I have discussed is an important tool for the clinician and can clearly be seen in operation within Elsie's portrait.

The Healing Process

I will now consider my view of the healing process in relation to Elsie's individual story, which I will relate to the wider context of medicine. The two main themes that will be examined are:

- What is healing?
- The process of healing.

What is Healing?

Elsie's story demonstrates to me that healing is much more than just 'curing the illness', and ultimately can only be defined by the individual not by the health professionals. Her GP summed this up when he said that 'we needed to get her back to a level she could function at'. Certainly it didn't make 'scientific sense' for Elsie to be put back on the same dose of amitriptylline on which she had relapsed; yet she was, and she recovered.

If we were to take a narrow technical view of this situation, we would be missing the key elements in Elsie's healing. Sadly, however, it seems to me this is the position we often adopt, especially since the advent of the evidence-based medicine movement. Rather than enhancing health care, as it was genuinely envisioned, it has detracted from other equally pertinent components. One of these components, I personally feel, is the moral basis of medicine, which I discuss in my reflections on professional practice in chapter four. Of course, sound technical expertise is essential

within medicine. In my role as a Consultant Psychiatrist it would be ridiculous, and in fact negligent, for me not to have a thorough understanding of the medications I employ. Obviously, this has to be updated and I must be aware of new developments within this field. But that is not the whole; it is one small component. It has to be appreciated that in medicine, as in any other situation, the whole is more than the sum of the parts.

Therefore, returning to the original question, healing is more complex than cure and I believe, from my own work as a practitioner, unique for each person. There can be similarities for two different people with the same condition, but healing will have a slightly different meaning or definition for each of them. I think that when the EMH team talk of a needs-led service as their aim, they are actually recognising the individuality of healing and their desire to promote this healing. However, it would not be acceptable in the current consumer-orientated health care environment to refer to aims in these terms of healing, either publicly or privately, whereas the terminology of needs is acceptable because it infers there is a commodity to meet the need. Individuals' perception of healing is influenced by many factors, including their beliefs and values, their life history, and their current circumstances. The definition of healing given by Donovan begins to capture these aspects:

> To heal is to become whole again and to return as far as possible to what one considers a normal life. Ideally, healing involves a cure, but when a cure is not possible, it still involves restoring function, maintaining function, or, at the very least, regaining the sense of balance and the integration of meaning and living. Therefore, the therapeutic activity of medicine need not cease even in a patient who is terminally ill.
>
> (Donovan 2000, p.16)

This definition of healing emphasises the patient's perspective. It is the view of a normal life that determines the goals and encompasses much more than simply a cure of a disease. Immediately prior to Elsie's first admission, her comment to the doctor was that neither he nor her GP had bothered about her and she'd been 'left to rot'. In fact she'd had quite intensive input from both of them but I think the issue was that

she didn't feel cared for, because at that stage the focus appeared to her to be on a cure of her disease rather than on her suffering. Notably, when discussing her admission, the doctor's comment to me was that it was necessary to demonstrate to Elsie that the professionals did care about her.

Cassell (1991) discusses the goal of medicine and states it is the relief of suffering. He describes the development of the prominent disease-based view that has evolved, not surprisingly given the great advances we have witnessed in our understanding of the workings of the body and its malfunctions. These advances are extremely important and no-one is suggesting otherwise. However, they have resulted in a very fragmented and simplistic view of the sick person. When the sick person presents to the doctor, they can be viewed as the embodiment of a certain disease process and the 'person' can get lost. The logical conclusion arising from this viewpoint is that if you cure/treat the disease process, the person will be well. We know in practice this is not a given; the simplistic 'a' plus 'b' will result in 'c' doesn't fit. From my experience as a practitioner, I have observed that two people with exactly the same disease process or pathology can respond in very different ways, and the sickness can have vastly different impacts on their lives. Cassell makes a distinction between diseases and illnesses:

> Diseases, for our discussion, are specific entities characterized by disturbances in structure or function of any part, organ, or system of the body. Illnesses, on the other hand, afflict whole persons and are the set of disordered functions, body sensations, and feelings by which persons know themselves to be unwell.
> (Cassell 1991, p.49)

The definition given by Cassell is pertinent to the understanding of healing, and why the views of the health professional and the patient can be so vastly different on occasions. In my experience, when this dissonance occurs between professional and patient, the reason often lies in the perspectives of the two. The issue is rarely that the professional does not understand the disease or its biological sequelae, rather the issues usually revolve around a misunderstanding of what this means personally to the patient in front of them. Kleinman (1988) also addresses this issue, and he

emphasises that the illness experience and suffering are linked but neither can be represented adequately in the biomedical or disease-based view. There has been I believe, a drive to replace a broader view of illness, including its social and cultural significance that has come to be seen as 'soft', with a technical/scientific 'hard' evidenced-based view. Society has come to invest much faith in technology and modern science. Most people assume it has the solution if we just look hard enough. Even though this may at times present an illusion of control, it is only an illusion, and maybe as a society we need to stop and consider our fear of uncertainty. An important point emphasised by Toombs (1993), who wrote from the perspective of both a philosopher and a person suffering with multiple sclerosis, is that loss of control and uncertainty is intrinsic to illness. This loss of control is perhaps the hardest aspect for any person in coping with illness and the hardest for professionals to acknowledge and cope with, both in their patients' and their own lives. The issue of the loss of control within illness and our desperate search as a society for certainty is crucial to the understanding of professional practice, and was examined further in the discussion of theories in practice earlier.

This is the transition point, I feel, we are at in medicine, moving away from the purely disease approach to the sick person. Focusing on the sick person, rather than the disease, includes all the technological advances we have, or will make, but embraces the wider and sometimes more important aspects of illness. The comments patients make to me, indicate that when they feel they are seen as a person not some disease process to be rectified, then they feel cared for. Toombs (1993) examines the phenomenology of illness, looking at the differing perspectives of the patient and doctor. She argues for the need to develop a shared world of meaning, for there to be a transfer of attention to the 'lived body disruption' perceived by the patient, away from the disease state. From a practitioner's perspective, I would certainly agree with her contention that for healing to occur there must be an understanding of the 'illness-as-lived'.

In writing the portrait of Elsie, my instinct was to place her in context by explaining her diagnosis of agitated depression. Only after doing that did I then introduce her as a person. Undoubtedly this reflects the medical viewpoint arising from the culture within which I am embedded as a professional. It illustrates the disease-based view

outlined by both Cassell and Toombs. However, acknowledging and recognising this disease-based view does not mean it is entirely wrong or should be abandoned. I would be a strange doctor if I were unable to diagnose and treat the disease appropriately, in Elsie's case agitated depression. The problem would arise if I then got stuck at this point and could not move on to the lived experience of the patient. The disease-based view, which I think links into the current evidence-based medicine movement, is just one of the tools I have. Toombs underlines this point, calling for professionals to step beyond the disease-based view:

> Rather, it is to suggest that he or she perform a temporary "shift in consciousness" from a purely "naturalistic" construction of the patient's disease to a lifeworld interpretation of the patient's disorder in order to gain a more complete understanding of the patient's illness. This shift in focus will not only provide insight into the human experience of illness but will enable the physician to address the patient's suffering more directly.
> (Toombs 1993, p.98)

It was essential for me, and the team, to recognise Elsie's distress. In many ways it was irrelevant to her what we said she had, in this instance a disease called agitated depression. For her, her life had turned upside down. She had lost her husband, there was a rift with her younger son, and she was worried about the future for her disabled son as she grew older. Her lived experience was one of panic and uncertainty, and she was desperate for the professionals to hear this message. Much of the healing for Elsie was in the knowing that she was heard. This is where the creativity or artistry of practitioners comes to the forefront.

The Process of Healing

In the previous section, the concept of healing was considered. I will now examine the process of healing from my perspective as a practitioner. For Elsie, there were clearly many factors involved in the process of healing and a major factor was the interaction that took place between her and the team. As I consider the process of healing, it demonstrates artistry within practice, not all of which can be analysed and

put into words in the way we have become accustomed to in the dominant view of science that currently prevails.

There is no doubt in my mind that for me, as a practitioner, my skill lies in creating an individual solution for the person consulting me. It rarely, if ever, occurs instantaneously but is a process over time. Elsie's story highlights this process. The solution had to be tailor-made for her - it just didn't work otherwise. When she complained of the side-effects from the medications, I would suggest she was actually telling us 'I'm different, I'm an individual, I don't fit in the box'. There was also an aspect where the professionals had to proceed at her pace and in her ordering. The assessing doctor called this 'her natural cadence'.

We are so caught up in our society with the quest for 'quick fixes' that we have lost sight of the need for time and patience in healing. West (2001, p.213), summing up his work with a group of inner city GPs, comments that the 'humane and meaning-making vision may be under threat from a 'quick fix', consumerist mentality, using drugs and behaviour modification.'

The healing process itself may be an innate natural process not something very easily acknowledged in our technologically-based view of life. It may well be that we can influence this process for better, or for worse, or we may need to stand back and allow it to proceed. Therefore, our role can be to stand alongside the patient while the healing occurs naturally. This is a vital role for health professionals, and underlines the fact that technology may have only a peripheral role, or even no role, in the healing process.

Dixon et al. (1999) examine the healing process from the perspective of general practice. They emphasise the healing effect residing in the person of the doctor. Cassell (1991) describes this as the clinicians lending their strength or wholeness to the patient whose own personhood has been disrupted by illness. Of course, a large element of this is intertwined in the doctor-patient relationship, which I consider in more detail later, but there are other, seemingly nebulous factors. These are nebulous. I would suggest, for two main reasons. Firstly, they have been and always will be difficult to verbalise in a precise manner. Secondly, we have become conditioned by

the accepted view of science, and in particular evidence-based medicine, that demands 'objective' proof to establish worth. These factors are demonstrated in the placebo effect usually regarded as the nuisance factor in the quest to conduct rigorous randomised controlled trials. Immediately, this viewpoint relegates them at best to worthless and at worst to detrimental. It is hardly surprising then that little attention within mainstream medicine has been given to them over recent years. However, the average placebo response is consistently of the order of 30% to 40%, increasing for some operative interventions to as high as 60% to 70% (Dixon et al. 1999). Cassell, commenting on the placebo effect, states:

> Rather than being seen as incidental, these influences, the placebo effect, and the other sources of bias noted above are so powerful as to make clear the fact that the model of a drug treating a disease is as artificial and removed from the care of actual persons as is the belief that diseases exist in and of themselves, separately from sick persons. (Cassell 1991, p.121)

I think there is no doubt that in Elsie's case these factors outweighed any technological (in this instance medication) intervention. She ultimately became well again on the same medication and at the same dose on which she had become unwell. It is also seen in her apparent resistance to medication changes and suggestions. So what were these other factors that contributed to her healing?

Trust

Trust is fundamental to the functioning of society and especially so in the practice of professionals. We need to appreciate that trust operates when there is no definite evidence or proof. As O'Donovan (2000) discusses in relation to both medicine and education, trust involves putting yourself in a position of vulnerability and handing over the control to another person. In taking this risk, there is an assumption that the professional in whom we trust recognises and accepts a moral obligation to us that will transcend their own interests. We expect the professional to have our good as the aim of any interaction with us, and that our best interests will guide their judgements

and decisions, not theirs or anyone else's interests. This is echoed in Jackson's (2001) discussion of truth, trust and medicine.

O'Neill (2002) in the Reith Lectures, examines the issue of trust and the current climate of suspicion in our society today, with particular reference to professional practice. An interesting proposition she puts forward is that, despite the current political preoccupation for openness and accountability through regulations, rather than engendering trust, this focus engenders mistrust. The reason she suggests is because the form of accountability being imposed has introduced perverse incentives. These arise from the performance indicators dictated by the government body, for example waiting times for operations. The indicators have been chosen precisely because they are measurable, and this often equates, although erroneously in society's thinking, as objective and valid indicators. In reality, these indicators detract from the real business of the professional, in this instance being a good doctor. The professional is required to fulfil the requirements of their paymaster, who sets the performance indicators to be achieved, rather than the needs of the individual who consults them. There is a subtle but extremely fundamental shift in professional practice, which undermines the basis of trust between doctor and patient. For trust to operate, patients need to believe that the doctor who is attending them does indeed put their interests first and foremost.

However, doctors are being obliged to consider the interests of their regulators first and patients second. For instance, despite being convinced that the evidence indicates a new drug may be of benefit to one of my patients, I can no longer act on that professional judgement. I must wait for this drug to be considered by the National Institute of Clinical Excellence, set up by the government, which will make a decision both as to the likelihood that the drug is effective and whether it is cost effective. It is probable that the earliest they will consider this drug will be in a year's time and my patient may be dead by then. I question whose best interests are being served.

Another key issue in our society is our emphasis on having access to more factual knowledge about professional issues, for instance being told of all possible complications of a procedure. There appears to be an assumption that having access

to this knowledge will protect individuals from untrustworthy professionals. This assumption is flawed in two major aspects. Firstly, information can be available but so can disinformation and how do patients discern the difference? Secondly, having the factual knowledge does not necessarily equip you to weigh it up and make the wisest decision. In both these instances we come back to a need to trust the individual professional to firstly, provide accurate information and secondly, to share their professional judgement with patients.

In all of the above discussions, the factors highlight the centrality of trust in the relationship between doctor and patient and emphasise that professional practice is a moral exercise and not just a technical intervention. Trust occurs when the patient comprehends that the doctor is operating with what Aristotle called 'phronesis', or moral wisdom. Interestingly, this is what Aristotle suggested was the basis for a professional, distinguishing them from a technician.

One factor that kept recurring in my discussions with the team and my own reflections on Elsie's case was the need for her to be heard and know that she was heard. This was an important first step to fostering trust with the professionals. Unless she was truly 'heard', how could the professionals start to make judgements about her best interests? Obviously, in a literal sense, she was heard right from the beginning, and as I commented as the researcher, the depth of the professionals' understanding of all the factors struck me. However, in a real sense she had not been heard and the professionals involved were aware of this.

This linked into gaining an understanding of the 'illness as lived' (Toombs 1993) but also bodily empathy (Rudebeck 2000; Heath 1995). I would suggest that when bodily empathy occurred, this was the turning point for Elsie and enabled healing to begin. She was then able to begin to trust the professionals and began to experience being cared for. One of the striking features in Elsie's story was the change she expressed following her first admission. Prior to this she described being 'left to rot'; following her admission, she talked at length of feeling really understood by the nurses on the ward and how important that was for her. She experienced bodily empathy.

Benaroyo, considering the process of healing, emphasises that the start of this comes with an in-depth understanding of the experience of illness, or as bodily empathy:

> Thus, a first task of *phronesis* is to find resources in the healer's language and experience of the world that enable the healer to find – or create – a common belongingness (*Zugerhorigkeit)*, a fusion of horizon, that unites the healer and the patient.
> (Benaroyo 2000, p.229)

He maintains that only after this occurs can trust develop which then facilitates the next stages in the healing process. It was after Elsie began to feel understood that she was able to begin to trust the team and start to move forward.

There is a depth to this kind of understanding when it occurs. As a practitioner there are definitely times when I am aware of its operation. It has a physical quality and I would certainly favour the use of the term bodily empathy. It also helps to move us away from the false distinction between the mind and the body that pervades Western culture; the Cartesian duality. Kleinman (1988) discusses this issue and how it has led to us in the Western world to lose sight of the interplay of society and culture within the illness experience. There has been a move to try and regain this perspective in the argument for a biophysical psychosocial perspective within medicine. Although this does go some way, in my view it still does not encapsulate the whole picture. I think the reason for this is that, in the biophysical psychosocial view, there is still an attempt to neatly box and control a complex human experience of illness. Barker, writing as a psychiatric nurse with many years' experience, argues for the need to recognise the role of artistic works in enabling professionals to better comprehend the patient's experience:

> The great value of these books is that they are more real than reality, by virtue – paradoxically – of their distance from reality. To get this close one needs to keep one's distance, which might be a form of dramatic irony in itself. These artistic accounts occupy a different body of human understanding from that of the biological,

> psychological or social sciences, which employ a different kind of distance from the subject: not in any way better, just different. (Barker 2001, p.23)

He eloquently conveys the value of this form of knowledge for the professional, further underlining the complex human experience of illness. At the same time, he does not discount the value of the other forms of knowledge, and as a practitioner I would strongly endorse his view. We have to accept that the human experience of illness goes beyond what is easily described or measurable. All the component parts, biological, psychological and social, are important but none of them are sufficient in themselves, and nor is their simple addition.

Elsie's story demonstrates that the development of trust is not a simple process. It involves more than just saying you trust this professional. It goes deeper into the person's belief system, which they themselves are unlikely to be fully aware of. I suspect that had I asked Elsie whether she trusted the professionals she would have said yes. Generally, doctors and nurses are felt to be trustworthy, despite recent crises. However, there is a difference between the general 'professionals can be trusted' to the interaction that takes place between the patient and the professional on a one-to-one basis. This is when empathy becomes an important foundation block for the trust to grow.

During focus groups with professionals within the EMH team and another psychiatric team looking at how we assess patients' needs, one of the major themes running through all of the groups was the importance of trust. It was viewed as the first essential ingredient before you could even begin to move forward, and had to be addressed no matter how time consuming it might be. There would be times when trust just couldn't be fostered – those situations were never felt by the professionals to be satisfactory and the patient's needs were then not truly met. In psychiatry, professionals can be faced with a situation where a patient has to be detained and treated against their wishes. All the professionals, when discussing this scenario, emphasised how vital they felt it was to then work at building up a trust with that person, and clearly saw this as the most important task. Certainly from the perspective of a practitioner, considering my own practice and observing colleagues,

in these situations a lot of time and energy is expended to try and do this, highlighting how importantly it is viewed in everyday practice.

The importance of investment to foster trust was summed up by a CPN in the focus group:

> 'Because I think the area around trust and the development of the relationship can sometimes take a long time before you can then actually move into…Yes, yes I think a lot of what comes after is dependent on that relationship and we have to be patient…Yea and it's not done in one session.'

An aspect that is pertinent to modern health care is the use of teams. It is unlikely that a patient will relate to one professional even within general practice, or perhaps better named, the Primary Care Team and there is a need for us to recognise and foster the development of trust with the team (Krogstad et al. 2002). The EMH team discussed how this trust is evident in their everyday practice. Team members commented that, meeting the patient later on in the episode of their care, they were aware that a trust was already established with them as an individual, because it had developed with the team. This was succinctly described by Elsie when she was discussing her experience of the nurses on the inpatient ward, and commented that they were 'all different, but it all merged in'. One of the team members stated:

> 'I think it's almost cumulative and I also think there's you – for instance if one has a family meeting sometimes it could be the first time I've met a family and yet you do get this feeling they trust you too – you've got over a hurdle already because they associate you with the group where they have trust already.'

However, caution is needed not to assume that this trust is either maintained between contacts or transferred to individual members of that team. In the focus groups, practitioners were clear that at the beginning of each contact it has to be checked out. Quite often this can be a quick, almost unconscious process and the practitioner will usually become aware of the process when something is amiss i.e. the trust has

broken down or altered in some way. At that point, the reasons for this and an attempt to re-establish the former level of trust become the focus of the interaction prior to any other work being undertaken. Likewise, a new member of the team becoming involved with a patient must check that the trust established with the team is transferred to them personally.

Before moving on from the aspect of trust within healing, it is important to emphasise that patients come with prior experiences, which will influence their ability to build a trusting relationship with the new practitioner or team. This was referred to as 'the baggage they bring with them' in the focus groups. Gray, Secundy and Jackson explore the issues related to engendering trust in a pluralistic society and list some of the possible obstacles to this as being:

- Historical violations;
- Alternative beliefs/explanatory meanings;
- Language/semantics;
- Lack of knowledge/inadequate information;
- Negative /hostile encounter.

(Gray, Secundy and Jackson 2000, p.66)

There had been definite violations of trust in the past for Elsie concerning the treatment of her son with learning difficulties, and her GP was aware of this when he commented that 'the system had failed her'. The need to be aware of a person's belief system was highlighted in the difficulties that arose with the Social Worker and this led to a complete breakdown of that relationship.

It is imperative for us as practitioners to remember that we do not start from a neutral position, and to endeavour to gain an understanding of where the person is and why so we can move forward together. Trust must not be taken for granted and needs to be constantly monitored for healing to be promoted.

Validation

Once trust has been cultivated, a major catalyst for this being the operation of empathy, the next steps in the process of healing can occur. Brody (1987) sees these as:

1. Feeling cared for;
2. The ability to give meaning to suffering;
3. Regaining a sense of control or mastery.

Heath (1995), considering the role of GPs, speaks of them being both the interpreter at the dividing line between illness and disease, and the witness to suffering. In her discussion of the dividing line between illness and disease, Heath is highlighting the drawbacks of the disease-based approach to illness that I discussed earlier, which can lead to unnecessary and sometimes dangerous interventions.

There is also a dividing line between distress and illness, which I believe is quite clearly demonstrated with Elsie. Distress is awareness, whether physically or emotionally, that something doesn't feel quite right. It is often non-specific and difficult to name. It is part of everyday life and in itself does not confer any specific privileges to the person experiencing the distress. However, once it is acknowledged as an illness by a health care professional, the person is allowed to assume the sick person's role. I would reiterate that illness and disease are not synonymous. A person can have an illness, for instance stress, that the GP signs them off from work with, but not a disease process. The experience, in particular the distress, is validated.

Clearly Elsie was very distressed when I met her. Once the EMH team became involved, and in particular when this was underlined by her admission to the inpatient unit, she was seen as ill. At this point, there was a significant change in her relationship with her younger son, and the rift between them was resolved. It was as if her son could not accept her distress because of his father's behaviour but he could cope with her distress because of an illness. Labelling this an illness allowed the relationship to be restored. The distress itself had not changed, just the perception of it.

There is also an aspect whereby naming the distress as an illness, or a disease process, allows it to be seen as a separate entity from the person, which in turn reduces its threatening nature. The distress or suffering is no longer part of the self that might have the power to destroy the self. It is no longer inherent and as such can be fought against or controlled. A sense of control or mastery can begin to be claimed by the patient:

> The name may mean very little to them; they may understand nothing of what it signifies; but because it has a name, it has an independent existence from them. They can now struggle or complain *against* it. To have a complaint recognised, that is to say defined, limited and depersonalised, is to be made stronger.
> (Berger 1967, p.74)

This validation of the person, who is now seen by themselves and society as ill, opens the possibility of feeling cared for, whether by professionals or others, making sense of the suffering and gaining a feeling of control over it. This is an aspect I am very aware of in my practice when patients come to see me.

Standing Alongside

In reviewing Elsie's story, and considering other patients I have known as a practitioner, 'standing alongside' seems to me to be the single most important factor in the process of healing. Whether we are able to offer a cure, relief of symptoms or merely an explanation of what is happening, the one constant factor in all of this is being with the patient. It is not coincidental that the image I had of the work with Elsie was that of a journey. Reflecting further on that imagery, I don't think of it so much as a completed journey represented by the illness, but rather that we join the patient on part of their journey, which is their life narrative.

This role of standing alongside does of course link in to the doctor-patient relationship, which I examine in greater depth in the next section. There is a need to be flexible and attentive, or in tune with the patient's needs, at that particular point in

time. Charles et al. (1997) propose a model of shared decision-making in the medical encounter. This can only be successful if there is an attempt to understand whether the patient prefers to take the lead in decision-making or if they want the doctor to take the lead. This of course can change in the course of the illness and needs to be constantly reviewed.

I think the important point here is being what the patient needs, to enable the process of healing. It is more than just shared decision-making, which is usually linked to an intervention. The basis of standing alongside the patient is the interaction between patient and professional, the transference. Unfortunately, this has come to be seen as something peculiar to psychiatry and in particular psychotherapy. Zinn (1990) looks at transference within the wider arena of medical practice, and makes the point that it is a powerful determinant of both patient and physician behaviour. This relates to the role within general practice that Heath (1995) discusses; of being a witness to the patient's suffering. Kleinman, writing about chronic illnesses, states:

> I have emphasised empathic witnessing. That is the existential commitment to be with the sick person and to facilitate his or her building of an illness narrative that will make sense and give value to the experience.
> (Kleinman 1988, p.54)

From a practitioner's perspective, I have always felt that being with the patient was just as important, if not more important at times, than doing. Yet I would not have been able to articulate clearly an argument as to why that was the case. However, having undertaken this research and having the opportunity to explore my practice, I am able to begin to articulate this aspect of it, which instinctively I knew was important, and to value it. It also gives me the opportunity to both promote and defend it in a culture that seeks quick fix actions.

Berger (1967, p76) talks of the doctor taking on the role of Everyman, in other words a representation of mankind as opposed to him or herself as an individual to whom the patient can relate. One of the biggest threats in illness is the feeling of isolation and uniqueness, separating the individual from mankind (Berger 1967; Heath 1995;

Kleinman 1988). In research interviews that I conducted with one patient, she constantly asked me whether I had seen anyone like her before, and whether she was unique. She was terrified that somehow she was alone in this experience and no longer part of mankind by virtue of her difference.

Our society does appear to have become individualistic and has largely lost sight of the relevance of our collective identity. Yet at a time of illness when our very existence may be threatened, our connection to mankind becomes important to our sense of well being. This important element in healing is often overlooked and the doctor may be the necessary instrument to allow this process to occur.

For Elsie, standing alongside in all of these aspects was vital for her healing. I would suggest this was also why the medication was irrelevant but symbolic in this process.

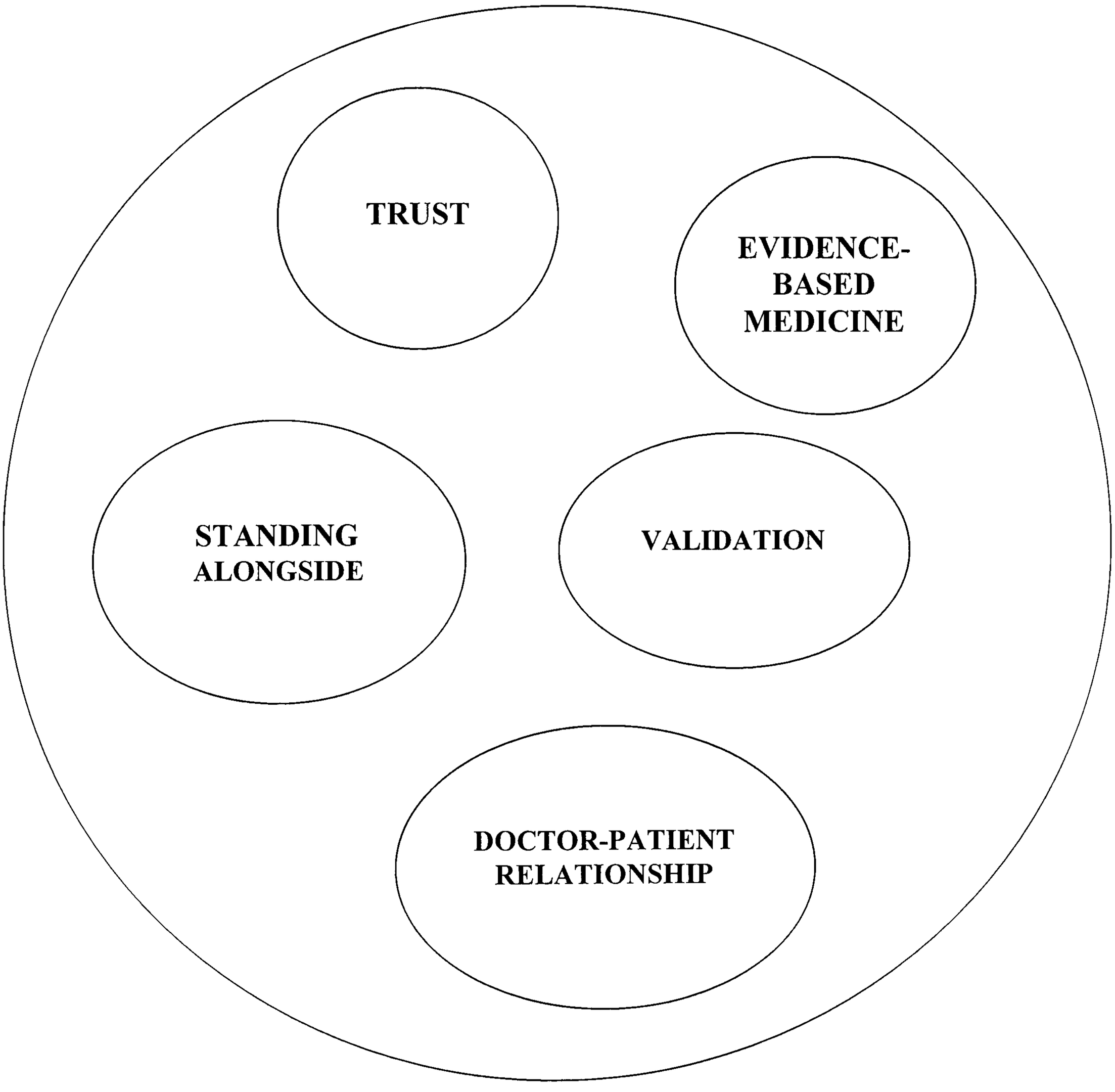
Creating the Solution

I have been able to discuss some of the aspects of the healing process, but as I stated at the outset, some aspects defy verbalisation. It has enabled me as a practitioner to bring awareness to parts of my practice that I see as foundational, but have not acknowledged consciously before and therefore not fully valued. My reflections have left me with the real sense that, for each individual, I and my practitioner colleagues do create an individual solution. The more in tune we can be with them, the better fitting the solution that ensues for them. There are various tools we can choose to employ, evidence-based medicine being just one of many, and sometimes it is as if we offer a menu to the patient who will then choose what is best for them. The key features are sensitivity and flexibility.

It is perhaps best summed up by the image of a large circle enclosing a variable number of smaller circles (Figure 1). The large circle is the healing process and the smaller circles inside are the tools we might use, for instance evidence-based medicine, doctor-patient relationship and standing alongside. However, the important point is that the large circle, or healing, encompasses more than just those inner circles – there is a mysterious part to it. Taking the image a step further, no

matter how many smaller circles you managed to name and cram into the large circle, there would still be irregular parts left uncovered that defy organisation.

Figure 1: The Healing Process



Doctor-Patient Relationship

Introduction

In Elsie's story, I felt, the most important factor in her healing was her relationship with the EMH team. It was through the medium of this relationship that the healing process was facilitated. If we consider the aspects of the healing process discussed in the previous section, namely trust, validation and standing alongside, none of these aspects could occur independently of a relationship. I would argue that if the relationship falters, then these factors are not able to operate and the healing process falters. There is a direct link between the role and relationship of the healer and the healing process, in the same way a building needs good foundations to be successfully completed.

Surprisingly, given the importance of the healer to the healing process, there appears to me, to be little emphasis given to the role of the healer within mainstream medicine in Britain. I have formed this impression both from my own experiences in training and practice, and from literature searches I have undertaken for this research and other projects. There are publications, both books (Berger 1967; Heath 1995; Downie and Macnaughton 2000; Kirklin and Richardson 2001) and articles (Brody 1994; Charles et al. 1997; Meryn 1998), discussing this topic, but rarely within standard textbooks and journals. Most of the standard texts concentrate on imparting facts and technical interventions.

When issues are addressed concerning the doctor-patient relationship, they usually centre on issues of communication. This is well demonstrated in the current concerns and debates about informed consent, and led to the development of a central policy on consent by the government (DOH 2001). Obviously, communication and information sharing is important, but it is only one part of a complex relationship. The rare and refreshing article I found originating in this country, published in the *British Journal of General Practice*, was a discussion paper by Dixon et al. in 1999 on the role of GPs. They argue that the doctor-patient relationship is fundamental to medicine, and sound a strong warning that if this relationship remains undervalued

we, both doctors and patients, are going to lose it. The authors emphasise the complexity of this relationship and the inability to fully articulate it.

There are, however, several articles examining the doctor-patient relationship in American journals. This became evident when I conducted a Medline search on the doctor-patient relationship. The finding suggests quite a different attitude between our two countries. There is an emphasis on evidence-based medicine in America, but I think a better-balanced view, with the literature indicating an acceptance and valuing of the other factors involved in the healing process.

There appears to me to be an underlying technical-rational assumption in most standard texts within British medicine. This assumption is expressed both explicitly and implicitly, and underlies the philosophy of evidence-based medicine. This assumption is that as long as the right technological intervention is chosen and applied correctly, it is immaterial who the technician is to the outcome. I have purposefully chosen the term technician, because in this scenario it accurately describes the role. Technological interventions include drug treatments, surgical procedures and even psychotherapy. Therefore, if this was correct, the person who attends the patient is irrelevant to the outcome, as long as they are competent in the procedure and adhere to the guidelines. There would be no reason why the patient shouldn't be seen by a different doctor or nurse each time they attend for treatment. On this basis, continuity of care would have no justification, and certainly no evidence base. Yet continuity of care, or the lack of it, is often one of the most contentious issues. Patients and their carers cite this as central to good care when you talk to them (Delbanco 1992; Krogstad et al. 2002). When complaints arise, they often centre on this issue, leading to feelings of inadequate care. I would suggest this is because the relationship between patient and professional has become marginalised. We need to listen to the patients' experience and consider again the role and functioning of this relationship.

Focus of Reflection

Here I reflect on the doctor-patient relationship not the health care professional relationship, and include personal reflections from my own practice. There are

several reasons for this decision, which I will now explain. Firstly, I am examining my own professional practice and I am a doctor. Secondly, all relationships are unique even though they may share some similarities. Obviously, the similarities are greater with colleagues who are doctors than colleagues who are nurses. It is not surprising that there are similarities in the doctor-patient relationship because, as a group of professionals, we share the traditions and culture of our profession, in this instance medicine. Equally, however, we also retain our individuality. Therefore, there are aspects unique to me. This does not however, negate the usefulness and value of these reflections. Rather, engaging in this reflection is enriching my practice, and the dialogue that can ensue from it with colleagues can be a catalyst to the development of their own practice.

Thirdly, I believe there are fundamental differences in the relationships of different groups of health care professionals and patients. This is despite the current political pressure, from whatever motives, to develop the generic health care worker. A doctor and nurse, for instance, are seen and expected to act differently by patients. The doctor who assessed Elsie discussed this during my interview with him. The information disclosed to each by the same patient is sometimes vastly different. This is one of the strengths of the multidisciplinary team and was certainly evident in Elsie's care. The different perspectives add depth to the understanding of the patient's situation. I would propose that, rather than trying to minimise these differences, professionals should acknowledge them and value them as strengths within a team setting.

Characteristics of Doctor-Patient Relationship

I now focus on the characteristics of the doctor-patient relationship (the anatomy) before turning to its functioning (the physiology). Whenever anatomy is studied at medical school, the study includes development both from the perspective of embryology and evolutionary aspects. In other words, the structure is seen in the context of its history. The historical context of the doctor-patient relationship is fundamental to understanding it today. Carr (1987) echoes the importance of this context in his discussion of an educational practice.

A useful starting point is to survey how the doctor-patient relationship has been seen in the past. Kleinman (1988), a psychiatrist and anthropologist, in his consideration of suffering, healing and its relation to the human condition, explores the relationship of the doctor. He interviews several colleagues and is reminded by one of them of the ancient roots of medicine:

> He offered dozens of luminous cameos from an immense store of professional experience in support of his contention that healing is rooted in an archaic human endeavour whose ancient lineaments – shamanism and priestly functions and poetic insights into the darker side of man's soul – are more a part of religion, philosophy, and art than of science.
> (Kleinman 1988, p.214)

This does remind us of our origins within society. It is easy to forget that science is a late addition; useful, yes, but it should not obliterate our appreciation of the earlier components. These are still essential, but in grave danger of extinction through neglect. The recognition and acceptance of all aspects of the healer's role will enrich medicine and bring benefits to our patients.

The doctor-patient relationship is a professional relationship. Therefore, to start our consideration of it we need to agree the basis of such a relationship. Many writers (Carr 1987; Fish and Coles 1998, pp. 3-14; Thomasma and Lee Kissell 2000) refer back to Aristotle's ethics when considering this question, and that is where I propose to return.

The Greek word praxis, or practice, referred in their culture to 'a distinctive way of life – the *bios praktikos* – a life devoted to right living through the pursuit of the human good' (Carr 1987, p.168). Certainly, medicine's goal is for the good of the patient, a human good, and generally medicine is regarded as a vocation rather than just an occupation, thereby involving a way of life for the practitioner. Phronesis, or wise action, governs praxis. Carr illustrates this:

> Hence, 'practical wisdom' is manifest in a knowledge of what is required in a particular moral situation, and a willingness to act so that this knowledge can take a concrete form. It is thus a comprehensive moral capacity which combines practical knowledge of the good with sound judgement about, what in a particular situation, would constitute an appropriate expression of this good.
> (Carr 1987, p.172)

This definition immediately clarifies that practice goes beyond technical expertise, because practice is a moral action and requires judgement to be exercised in its execution. The acceptance of this takes us away from a purely technical basis to the practice of medicine, and has important implications for the doctor-patient relationship. The basis on which this relationship is founded is a moral one and seeks the good of the patient. Donovan (2000), examining the work of Pellegrino and Thomasma (1988), endorses their argument that the doctor-patient relationship is one of beneficence. If we look at the proposal that the doctor-patient relationship is a beneficent relationship, we will see that this encompasses Aristotelian thinking. Donovan describes the beneficent relationship as:

> The physician performs a 'right and good action' on behalf of the patient. The action is *right* if it is scientifically correct and medically valid. It is *good* only if it meets the needs of the patient in that particular circumstance *according to the patient's values.* Therefore, a good action by the physician is a moral action aimed at restoring health to the patient. Health, however, is regarded as a negotiable good that may move up and down a hierarchy of values as perceived by the patient. Medical treatments are neither prescribed nor withheld without consulting the patient's values.
> (Donovan 2000, p.19, italics in original)

I have chosen to include this lengthy quote because it aptly expresses the nature of the beneficent relationship. It conveys the principles that I, as a practitioner, believe are foundational to my practice. One of the reasons this model of the relationship fell into disrepute was because of the fear of paternalism. A paternalistic model

emphasises the physician's autonomy and right to make decisions based on their values. However, the beneficent model underlines the patient's value system as the basis for decision-making. This is vastly different from what I would contend has become the reaction to this, where the physician provides technical information and avoids forming a deliberative judgement based on the patient's best interests. The patient's best interests mean basing your judgement on their perspective, as far as you are able to comprehend it. There is also, quite rightly, the opportunity for the patient to disagree with and reject the physician's decision.

Being paternalistic should not be confused with taking an appropriate lead in decision-making. The stance doctors adopt with patients has to be flexible, and in this respect is on a continuum. At one end, there are patients who want you to take the responsibility for decisions, to tell them what to do. At the other end, there are patients who want you to give them all the facts, as far as that is possible, and then choose the course of action to be taken. Even in giving these 'objective' facts, we should not be deceived into thinking that no judgement is involved. The needs of a patient may alter during the course of an illness. At the beginning, when they can feel particularly vulnerable, they may need the doctor to be directive, to take a paternal, but not, I emphasise, a paternalistic role. There is a need for the patient, when they feel out of control, to perceive that someone else is in control. In a real sense, illness can be experienced as a loss of autonomy. As they recover they will usually regain their sense of autonomy and become independent of the doctor. During the research interviews, one patient commented how nice and friendly his GP was, but he did wish he would be a doctor sometimes and make a decision. Savulescu (1995) echoes these thoughts and argues that medicine is not just being a fact provider but inherently involves making judgements.

By its very nature, the relationship is not one of equality. The doctor possesses specialist knowledge and skills, and is also the gatekeeper to medical care. The patient is vulnerable, both because of the doctor's position, and also because they are usually seeking help for symptoms that are suggestive of illness and are disrupting their lives. Understandably, even the most confident people can be frightened and apprehensive.

The inequality of this relationship places particular demands or obligations on the doctor. The doctor must place the needs of the patient foremost, and his or her own needs become secondary. Furthermore, self-interest or gain would not be expected to be present. This echoes the principles of praxis. Donovan (2000) calls this self-effacement, which is a requirement for the doctor to exercise. From a practitioner's perspective, self-effacement is necessary and an expectation both practitioners and patients have within the relationship. I know when I see a patient it is irrelevant to them at that moment how busy I might be or what personal worries I have. They expect, quite rightly, that during the consultation they will be the centre of my attention. This is the reason, I think, why some patients can demand immediate and prolonged attention from me, even though it can be unreasonable. For them, when they are ill and vulnerable, it is as if they are my only patients, and they alone have the right to me, the doctor. I am not suggesting this is the case with every patient. When this demand does occur with the more extreme cases, it serves to illustrate an underlying principle of the doctor-patient relationship, because the principle is exaggerated and therefore more readily appreciated. I would stress this can occur with quite normal, well-balanced people. In a different context, they themselves would appreciate and be concerned about the unreasonable demands placed on health care practitioners in the NHS. This is peculiar to the doctor-patient relationship and is an important factor that sets it apart from a friendship or a business relationship. There are pressures in our society to see the relationship in these two terms, both of which I argue are inappropriate.

Viewing the doctor-patient relationship as a friendship in the current climate is appealing because of the sense of detachment and depersonalisation in medical practice. This sense of detachment, especially prominent on the technical side of medicine, has led to the call by some to view the doctor-patient relationship as a friendship. The idea of a friend immediately conveys someone who cares for you personally and is usually trustworthy. These are the aspects that can seem to be lacking in the present medical culture. Yet a friendship is based on two equal partners who have an equal duty of care for each other. I have just argued that neither of these two features is true in the doctor-patient relationship. Davis (2000) illustrates this point by referring back to Aristotelian ethics. He also raises a further important point that both partners enter into friendship freely, in other words it is a choice. Again,

there are many instances when this is not true for either partner. Patients certainly do not have a choice when they present as an emergency in casualty. There is supposedly a choice about whom your GP is, but often it isn't a reality. Doctors do not choose their patients; in their role as doctor they fulfil their duty to care, but it is unlikely that in a social situation they would choose their patients as friends.

Another important difference between these two types of relationship is the emotional aspect. In a friendship I would invest a great deal of personal and sometimes costly emotions. There might be times when I would become emotionally identified with a friend; in a real way their burdens can become mine. These emotions are at a deeper and more personal level than with a patient. This does not mean I am not emotionally involved with my patients, but at a different level. In the relationship with a patient, empathy is at the forefront. It allows me, the doctor, to emotionally engage with the patient, but also to maintain the distance necessary to be their doctor. This detachment is called a 'necessary inhumanity' by Richardson (2001), who discusses its necessity and development from the first day of training. The issues surrounding empathy and, in particular, what it is and what it isn't, are examined in detail in the following section.

A further reason against seeing the doctor-patient relationship as a friendship relates to the above point. If we consider friendships, each of us has a close circle of friends that is finite because it demands ongoing investment from both parties. Most of the other relationships we have, outside the family, would probably be described as acquaintances. Simply on this basis, it would be inconceivable to imagine that a doctor could have that close level of friendship with the number of patients seen every day of their working lives. In contrast, it is feasible for doctors to have a beneficent relationship with all the patients they have contact with. This relationship enables the doctor to care and be involved in the emotional way that patients need.

The pendulum has also swung to the opposite pole and pressure has been exerted for the doctor-patient relationship to be viewed as a business relationship. This, I suggest, arises from a political pressure to manage health care and has been enhanced, knowingly or unknowingly, by the evidence-based medicine proponents. We live in a consumer-orientated culture, so in one sense it is not surprising that this

has arisen. With the advent of evidence-based medicine, and its seeming removal of the human element from practice, health becomes a commodity to be acquired. The human element is not just the nuisance factor of doctors not having kept up-to-date with the latest evidence; it is more fundamental to the practice of medicine. The human factor that has quietly, almost silently, been removed from the equation is judgement or 'phronesis'. The negating of phronesis, with its inherent focus on the good of the individual, in this instance the patient, is responsible for the loss of emotional well being and trust for the patient and the doctor.

In this proposed model, health is a commodity, like any other that you might buy at the supermarket. The doctor becomes a salesperson with an obligation to give you accurate information, but then the choice is entirely yours and a salesperson does not have a moral duty to promote your good. Even as I write this, it has alarming similarities to the language within the recent government policy on consent (DOH 2001).

Downie and Macnaughton (2000) discuss the workings of the doctor-patient relationship in an evidence-based medical world. They suggest that humane judgement bolted on to evidence-based medicine will remedy recent problems. However, I do not feel that they have fully grasped the fundamental moral nature of the doctor-patient relationship and the full implications of wise judgement or phronesis. The flaws inherent in the evidence-based medicine view of professional practice do not appear to be appreciated. Their argument for humane judgement seems to me rather more a call for doctors to develop a better understanding of a patient's feelings, something close to a bio-psychosocial awareness as opposed to deliberative judgement. In fact, their argument on the core values, proposed for the medical profession in the 21st century at a summit held in 1993, was that they were moralistic and non-specific. They specifically list 'commitment, caring, compassion, integrity, competence, spirit of enquiry, confidentiality, responsibility, and advocacy' (p.91) to illustrate this point. They suggest that the question should have been 'What is the good doctor good at?' Whether they are aware or not, I feel this reveals unequivocally their firm stance within the epistemology underlying evidence-based medicine in its current form. The basis is a technical-rational model and does not have a moral foundation. From a practitioner's point of view, I would strongly refute

this and endorse wholeheartedly the core values listed. Alongside this, the theoretical arguments earlier in this section also disprove these assertions.

Although I have serious differences of opinion with their view of the doctor-patient relationship, I do feel Downie and Macnaughton argue strongly and aptly against the consumer-orientated approach to medical practice. They suggest, and I would concur with them, that consumerism is a major threat to medical practice and something that is insidious. Doctors don't recognise consumerism as a threat and often erroneously encourage it because the consumer model appears enlightened and reasonable. Confusion, however, centres on the concept of autonomy, by placing an absolute right for the autonomous patient to refuse treatment, but not the converse right to demand that a doctor provides a specified treatment. The latter is a consumer-based right. They sum this up as follows:

> It is important to note, however, that autonomous choice or informed consent in this sense takes place within the context of a professional consultation, with the patient retaining the right of veto to unwanted treatment, and the doctor retaining the right of veto to treatment professionally considered useless or harmful.
> (Downie and Macnaughton 2000, p.95)

Interestingly, here they are alluding to professional judgement in the sense described by Aristotle, but unfortunately miss its import to their earlier discussions. There seems to be an assumption of a common understanding of the professional consultation whereas, were they to examine this, it might have led them to different understandings of the doctor-patient relationship.

Lown is a respected cardiologist and scientist with over 45 years of experience. He is certainly well acquainted with the technological aspects of medicine and the evidence-based culture that has emerged. He practices in America and has witnessed the growth of consumer-based health care. He writes on the lost art of healing and issues a grim warning:

> It seems to me that medicine has indulged in a Faustian bargain. A three-thousand-year tradition, which bonded doctor and patient in a special affinity of trust, is being traded for a new type of relationship. Healing is replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technological procedures. Doctors no longer minister to a distinctive person but concern themselves with fragmented, malfunctioning biological parts. The distressed human being is frequently absent from the transaction. (Lown, 1999, p.xiv)

This succinctly illustrates the far-reaching consequences both consumerism and evidence-based medicine are exerting on our profession. Lown's comment emphasises the enormity of the change from a historical perspective and the consequences for the patient.

I am now going to focus on the functioning of this unique relationship between doctor and patient.

Functioning of the Doctor-Patient Relationship

There are times when I am aware that the doctor-patient relationship is working well, both from the position of a practitioner and as a patient myself. As I paused to consider these instances, I became aware that they occurred when a 'sense of connection' was present between doctor and patient. Interestingly, these episodes were unrelated to any technical achievement. In fact, some of the most poignant times arose at a point when technology had nothing whatsoever to offer.

If we consider the portrait of Elsie, her turning point came when she felt that the team had heard her. None of the technological interventions, namely the rational and evidence-based prescription of antidepressants, had the desired effect until this point, and whether they actually had an effect in the end remains questionable. I would suggest the overriding factor in her healing was this 'connection' with the team. Dixon et al. (1999), discussing the role of the GP as a healer in our evidence-based medicine world, make the following point:

> In reality, consultations are far more complex, vague, generous, and difficult to measure. For instance, the consultation frequently is itself the treatment.
> (Dixon et al. 1999, p.311)

In this comment they are stating a fact known by many practitioners but rarely made explicit because it does not fit with the current evidence-based view of medical practice and the ensuing technological view of medicine. Matthews et al. (1993) highlighted the importance of the connections between patient and doctor to the therapeutic outcome; they coined the term 'connexions' in their discussion. Therefore we must examine the factor that promotes this 'connection'. This factor is empathy and I believe, from a practitioner's perspective, it is one of the most important elements in the healing process.

Empathy is one of those terms that has come to be used easily within medical circles, but often without full consideration of what is meant by it. In these circumstances there is a danger for it to become so vague and elusive that it retains little value. I would like to redress that to some extent through the reflections arising from my own and colleagues' practice, and by drawing on some pertinent literature.

There is a close link and often confusion between the terms empathy, sympathy, and compassion. The definitions in the New English Dictionary (1994) highlight important distinctions. Empathy is 'the capacity for participating in and understanding the feelings or ideas of another' whereas, sympathy is an 'agreement of ideas and opinions'. Compassion is defined as 'sorrow for another's sufferings; pity'. When exercising empathy you can understand another's feelings or see things from their perspective without necessarily being in agreement with this perspective. For instance, I can understand why a patient is angry with professionals after being diagnosed with Alzheimer's disease. I can empathise with the anger and convey this as such, but it doesn't mean I *agree* with the anger. Furthermore, having connected with the patient's perspective, I can allow this to inform our interaction. Similarly. I may be moved with sorrow at my patient's suffering. Indeed, if I wasn't so moved at times I would worry about my fitness to practice. However, if I was moved to that

degree by every patient, I would quickly be emotionally burnt out. I can and do seek to develop empathy with each of my patients. This also relates to my earlier discussion about the doctor-patient relationship not being a friendship.

Franke (1995) discusses physician-patient communication in light of the pressures of high-tech medicine, and clearly argues the point that what patients want most from their physician is to know that he or she cares about them. She then goes on to elucidate ways in which this can be conveyed in the consultation, but misses the central core of the matter – the operation of empathy. She highlights techniques, all of them valid, but without the essential factor of empathy they are nothing more than techniques. Coming from a background of psychiatry, with a special interest in psychotherapy, I have observed the use of many different techniques. However well a technique is practised, if the element of genuineness is absent then the technique will fail. For instance, in active listening the therapist is taught to mirror back to the client what they have said. For example, the client says 'He made me so angry' so the therapist replies 'You were so angry'. Used in the appropriate way this technique conveys to the client that they are being heard. However, used just as a 'clever technique' rather than genuinely seeking to understand what the other person is saying, the technique is irritating and patronising. Likewise, I feel there is a danger within the doctor-patient relationship to just concentrate on techniques for communication and miss the issue of fostering real communication. This is what I would argue happens in Franke's paper.

In contrast, Spiro (1992) discusses empathy and whether it can be taught. He talks of it being an 'almost magical' phenomenon. This is an apt description because there are elements of empathy that remain mysterious and ineffable, in a similar way that there are elements within practice that defy elucidation. Rudebeck echoes this in his discussion of bodily empathy. He states it is a clinical method, a method beyond method, and is 'the point where nothing is to be said' (Rudebeck 2000, p.8).

There are aspects of empathy that can be verbalised and the understandings derived from psychotherapy are particularly helpful in this. This is one important example of the wide-ranging benefits of a psychotherapeutic understanding relevant to all

medical practitioners, and not limited to just psychiatry or to the speciality of psychotherapy. Unfortunately, this is often how psychotherapy is viewed.

Halpern (2001) is a psychotherapist and completed a PhD exploring the workings of empathy. Her clear distinction of empathy, from either detached concern or sympathetic immersion, was particularly clear and helpful. I would agree that practitioners frequently swing from one position to the other, sincerely believing that they are indeed exercising empathy. The first stance of detached concern is one of recognising the patient's emotional state but not engaging emotionally with the patient. This is certainly a cold and 'clinical' stance, evoking the picture of the detached observer in a laboratory setting. Some would argue this is necessary to prevent burnout. However, studies show the opposite (Roter et al. 1997): detachment correlates with lower work satisfaction, which is a precursor to burnout. Indeed, this model lends itself to the use of techniques that I discussed earlier and certainly does not convey genuineness to the patient.

The second stance of sympathetic immersion involves total identification with the patient's emotional state, in psychotherapeutic terms, a merging: I am you. At this juncture, the involvement is so intense that the doctor cannot maintain any distance to stand back and formulate judgements. This can be disastrous and render the doctor impotent in the situation. For instance, a patient can be despairing following a serious accident that leaves them paraplegic. They feel there is no hope of any quality of life and as a result will not engage in rehabilitation. A doctor may identify totally with that despair and collude with the belief that rehabilitation is pointless. The patient remains in despair and makes no progress. The doctor needs to 'feel' the patient's despair and convey that to the patient, but then he needs to enable the patient to move through that to regain a meaningful quality of life, albeit different to what they knew before. That, after all I believe, is the role of the healer.

Empathy operates between these two extremes. Halpern (2001) talks of the emotional reasoning that sensitises the doctor to the emotional state of the patient and, importantly, the subtle nuances of this state within each individual. This cannot occur without the doctor being aware of the emotional resonance within themselves to the patients. Gorlin and Zucker (1983) and Zinn (1988) emphasise the necessity for

doctors to recognise what their own feelings tell them about the patient's emotional state. We all experience this in everyday life; we see someone laughing and we find ourselves wanting to laugh. Emotional resonance is the first step and must not be mistaken for empathy. The crucial issue is for the practitioner to comprehend the situation from the patient's interior perspective. This requires the use of imagination; the ability to say 'I might be you'. Viewing things from the interior perspective of the patient is essential to avoid practitioners imposing their views and beliefs about the issues. This model encompasses an emotional involvement but enables some distance for the practitioner, releasing them to connect with their patient while still functioning as a healer.

Although Halpern's review of empathy from a psychotherapeutic standpoint is invaluable, it is not the whole story, as she herself comments:

> Empathy supplements objective knowledge, and the use of technology, and other tools for making accurate diagnoses.
> (Halpern 2001, p.94)

She quite rightly envisions empathy from a psychotherapeutic viewpoint making important contributions to the diagnosis, but Rudebeck (2000) argues for the recognition of bodily empathy and its importance in accurate diagnosis. He believes it is a communication of the lived experience of our bodies, whereby the doctor comes to an understanding of the experience of the patient's symptoms. This again demands a subjective experiencing of the patient's interior, but almost more visceral or physical. As he illustrates, the mind and the body are a single entity not two separate ones.

Rudebeck describes his rationale for an existential anatomy as 'a grounding into the human matters of bodily existence, and thus of life and death, where the doctors themselves are as deeply involved as their patients' (p.8). This resonates with Berger's description of the doctor as the 'Everyman' to the patient. The following quote from Berger's writing illustrates this and is included in full because a great deal would be lost if I attempted to summarise it:

This can be achieved by the doctor presenting himself to the patient as a comparable man. It demands from the doctor a true imaginative effort and precise self-knowledge. The patient must be given the chance to recognise, despite his aggravated self-consciousness, aspects of himself in the doctor, but in such a way that the doctor seems to be Everyman. This chance is seldom the result of a single exchange, and it may come about more as the result of the general atmosphere than of any special words said. As the confidence of the patient increases, the process of recognition becomes more subtle. At a later stage of treatment, it is the doctor's acceptance of what the patient tells him and the accuracy of his appreciation as he suggests how different parts of his life may fit together, it is this which then persuades the patient that he and the doctor and other men are comparable because whatever he says of himself or his fears or his fantasies seems to be at least as familiar to the doctor as to him. He is no longer an exception. He can be recognised. And this is a prerequisite for cure or adaptation.

(Berger 1967, p.76)

This quote summarises most of the previous discussion about empathy. Unlike the previous writings I have looked at, he considers the situation entirely from the patient's perspective, perhaps a timely reminder for us reading this over thirty years later. I believe he conveys an important truth and is imparting the whole of empathy, even though he doesn't use this term, including the mysterious and ineffable aspects. He can do this because he is writing from an artistic perspective not an analytical one. My own view is that his work *A Fortunate Man* captures and conveys the essence of the doctor-patient relationship far better than most of the modern papers and writings on this subject. Unfortunately, I doubt that you would find this work included in a medical curriculum and, sadly, I think it is out of print.

In drawing to a close, I would emphasise that I have concentrated on the concept of empathy. I have chosen to do this because for me, as a practitioner, it is the essence of the functioning or, to use my earlier analogy, the physiology of the doctor-patient relationship.

Conclusion

There is no doubt that each doctor-patient relationship is unique and individual. The reflections arise from my own experiences. This is after all a complex human interaction influenced by the individuals involved and by the cultures and traditions within which the relationship is embedded. There are common characteristics and ways of functioning that I have considered in this reflection, but no two relationships will be exactly the same. The portrait illustrates how fundamental this relationship is to the healing process, which has been supported by the literature I have considered.

THE WHOLE PICTURE

In this critical appreciation, I began with the whole picture then, as it were with a camera lens, I focused in on certain aspects in detail. Now, at the conclusion, I am taking a step back to survey the whole picture again. In these final reflections, I also have the benefit of hindsight and further opportunity to consider the piece of practice and the portrait that arose from this. The process I have undergone in producing this appreciation has highlighted for me the importance of reflection. However, reflection takes time – I don't think meaningful reflection can be hurried – and occurs on several layers. This has been a journey of discovery for me. Although I have to draw a line to complete this work, I am well aware that the reflective process will continue and has no ending for the professional. If I were to return to this critical appreciation in a year's time, I suspect it would look quite different.

Tools Chosen to Paint the portrait

Some of the tools I used to create the portrait were conscious decisions that I was aware of at the outset. Others were unconscious decisions that will become evident as I now look at the finished portrait. Many, if not all of them, will have been refined and developed in the production of the final piece of work. The tools are in themselves important because they were chosen, consciously or not, in an attempt to convey the essence of the portrait. I would suggest that in the actual production of the final piece I, the artist, became aware of the essence I am seeking to convey.

This mirrors the process an artist undergoes to produce an oil painting. They start with a sense of the concept or 'truth' they wish to develop and convey. At this stage, that sense can be quite vague and difficult for them to even begin to articulate to themselves. The artist then begins the painting, which undergoes many changes, with the artist trying different techniques, for instance brushstrokes, until they are satisfied with the final result. This is the point at which many artists fully understand what they sought to convey in their painting. The understanding comes from the process, including the tools employed, and the finished piece. The creation informs the creator and gives form to elusive or difficult to articulate concepts.

I am therefore going to consider the tools I chose to use, and reflect on what they may reveal to me about the episode of practice I was seeking to convey. I will be considering:

- Content;
- Form;
- Style;
- Tone;
- Nuances of colour and shading.

Content

I chose to paint an episode of professional practice with an EMH team that I had worked with previously in my training. This was partly opportunistic because I was working with the team during the planning stages, but equally this did not mean my research needed to be based within this setting. At the same time, I also 'knew' that this was a team I would like to work with in this project. Now, at the conclusion of this work, I would like to unpack the reasoning or sense of knowing I felt for my choice. This also illustrates to me how the reflective process revealed aspects of professional practice that are below the visible surface and yet constantly inform my professional choices, irrespective of whether I acknowledge them or not. Of course, if

I do acknowledge them, this opens the opportunity to evaluate them. I have come to realise that my choice in working with this particular team was a purposeful one. The basis for this choice is underpinned by beliefs and values that both the team and I share.

At the outset of this project, and just after I returned to work with the team as a Senior Registrar, we had an away day to consider the issue of being a needs-led team. This arose at a time when evidence-based medicine was coming into the fore and impacting on all clinicians. There was, and still is, vast political pressure to conform to a consumer-based view of health care. Clinicians were being pressurised to view themselves as technicians to provide the services chosen by their consumers, the patients, hence the title of the away day: 'Being a needs-led service'.

However, looking back on that event, I sense the issue the team was really grappling with was how to act in the best interests of each patient rather than be mere technicians who simply respond to demands for services. At that time we were unable to articulate, or even fully acknowledge to ourselves, this dilemma, partly because we were trapped in the rhetoric and view of practice that was being so strongly canvassed. This led to a partial comprehension and capturing of these issues reflected in the conclusion that arose from the day. We all agreed that the aim of the EMH team was to be a needs-led service geared to the individual patient, as opposed to a service provider. Underlying that statement, I believe there is a deeply held conviction within that EMH team that a professional engages with each individual in a unique way and seeks to promote that individual's best interests. This is not a technical intervention but a moral engagement.

For this EMH team, practice has primacy and the individual patient has centre stage. This team seeks to function individually as practitioners but also as one team. This was best summed up by Elsie's comment about the inpatient team as being 'all different, but it all merged in'. They are professionals, not technicians, and they demonstrate artistry in their practice, which is a moral exercise. I share these deeply-held beliefs and values with them, and I feel this is the reason for my choice to work with them. These beliefs influenced my choices, even though at the outset I was largely unaware of them apart from a vague 'gut feeling'. I would contend that the

portrait and critical appreciation excavated those beliefs and enabled them to come to the surface to be both acknowledged and evaluated.

This struggle seen within the EMH team on that away day is mirrored in the development of this study. I left the away day with a sense of wanting to explore further some of the discussions that took place. Initially, I considered a piece of work looking at patient pathways through the service or mapping. This evolved to thoughts of a survey to ascertain if patients felt their needs were met. Further discussion gave birth to my initial study of a needs-led service involving case studies of patients as they went through the service. However, I was still left with the feeling that I wasn't really addressing the fundamental issue, even though I couldn't exactly articulate what that was. This culminated in the final piece presented in this thesis with the portrait of practice followed by a critical appreciation. In the process of reflection, I realised the central issue I was struggling to articulate was the artistry within professional practice. I believe this was the underlying concept we were struggling to bring to the surface on that away day, and the team valued this artistry. The shared belief in the value of artistry in professional practice, even though it could not be verbalised, was the reason I sought to engage in reflection with this team.

Form

I have adopted the form of a portrait, which as I discussed earlier can be viewed as a specialised case study. This is ideal because it merges two important aspects. Firstly, case studies are familiar and accepted within the medical community; they have a long tradition for the impartation of information. Therefore they have acceptability within my particular professional community. Secondly, this form uses the concept of a portrait, thus facilitating the exploration of artistry. The case study, which is familiar, is being used as the basis to move into the unfamiliar; it is like a stepping-stone enabling us to step to the next one deeper in the river.

Style

Looking at the style of the portrait, there is a tension within the writing between scientific and artistic presentation. The word 'tension' here seems apt for several

reasons. Firstly, as the author, I am struggling to move away from an exclusively scientific basis and view of practice which I have grown up in and continue to practice in. This is further underscored and highly valued within our political climate, which favours a technical-rational view of practice. In many ways, in continuing with this work, I am swimming against the main tide within medicine at this moment. Secondly, health care professionals are grappling with these very tensions as illustrated at the beginning of this research when the EMH team was struggling to understand the dilemma they were facing within their own practice. The struggle continues to be evident in the journey undertaken to explore an episode of practice. Thirdly, in the wider arena of professional practice, this tension is evident and is, I believe, at the heart of the crisis professionals face. Society is questioning the place of professionals because society needs to know the difference between a professional and a technician. This issue is explored further in the chapter on professional practice.

The tension mentioned above reveals itself in the need I felt to set the scene by explaining Elsie's medical diagnosis, thereby legitimising the piece of practice from a scientific standpoint. At the time of writing the portrait, I would have said the reason I was starting with this was to enable my audience to understand the events. In retrospect, however, I think I was starting with a familiar base or foundation from which I could then venture into the unknown. There is no reason, though, why the diagnosis had to be stated in order to put this piece of practice in context.

Throughout the portrait, I am careful to present the narrative details in the same manner I would adopt if presenting at a case conference, but intertwined within them are my own and the team's reflections. These reflections employed artistic means such as metaphors to illustrate the artistry within the piece of practice. The reflections, or artistry of practice, become progressively more prominent as the portrait develops. Interestingly, by the end of the portrait I have left the medical diagnosis behind and I am seeking to understand the true nature of healing for Elsie. I have the sense by the end that I am now comfortable in this new terrain and can let go of my need for security from old, familiar ways. I hope that this can also be the experience for my readers.

The metaphor I used for Elsie, of being ushered into exposed and uncharted land without the benefit of previously available shelters, may also have relevance to the work of creating this portrait. The comment at the end of the portrait that 'it often meant being in the swampy lowlands (Schon 1998), and scrabbling up steep hills, not being sure of the correct path, but we got there together in the end' is as true concerning the painting of this portrait as the reflections about the episode of practice and the practice itself. The three processes mirror each other.

Tone

The tone of the portrait is conversational. This is unusual in academic writing but I would argue justified given the nature of the work. This is a conversation between professionals. The work is making explicit the conversations professionals have with themselves about their practice and with each other as they seek to come to a greater comprehension of the complexities of the situation. Within the portrait I seek to record this conversation as it takes place. This is to allow the readers, both fellow professionals and the wider audience, to glimpse how professionals labour individually and corporately as a team, to grasp the whole picture of the person who presents to them. This is illustrating one aspect of professional judgement.

An oral culture predominates in medicine. Many doctors, including myself, are far more comfortable using an oral medium than a written medium for conveying thoughts and ideas. Therefore, many of us naturally adopt a conversational style when we attempt to put things into writing. If we become so preoccupied with perfecting our written style, there could be a danger that we lose the essence of what we are trying to say, or become too discouraged to attempt to put the thoughts in writing. Although we might still develop those thoughts, their potential impact and circulation would then become limited.

Colour and Shading

This is an exploration of an episode of professional practice. Various techniques were used to bring this alive and to make it real for the audience. In comparing this to the painting of a portrait, these aspects could be compared to the nuances of colour and

shading an artist would employ, placing some aspects at the forefront and others, while important, in a supportive role in the background.

Elsie is in the foreground and is a central figure in the portrait. A lot of time has been spent painting a detailed picture of this woman to enable the reader to comprehend the episode of practice that ensues. At the start of the portrait I labour to describe in great detail my first encounter with Elsie to enable the reader to experience something similar to my experience of meeting Elsie. To understand professional practice, there has to be a grasp of the individual around whom all the professional judgements revolve. This is a moral endeavour to determine the best interests of that person; you could not achieve this without spending time with them. If this was just a technical intervention, time would be needed to determine the diagnosis and appropriate intervention, but not to fully understand the individual. The detailed description is being employed to enable the reader to form a relationship with Elsie in a similar way the professionals do, and out of this relationship professional practice emerges.

In contrast, the professionals as people remain in the background. They are there and their voices are clearly heard and highlighted in the portrait, in the conversations I described earlier. But as individual people with names, personalities etc., they remain in the shadows. This was not a conscious decision and took me quite by surprise when I realised this had occurred. Initially it disturbed me. I actually believe that who we are individually is inseparable from our professional selves. This is highlighted in my consideration of the doctor-patient relationship and in a later chapter when I consider reflection on practice. So what is this revealing within the portrait? It relates, I think, to the relationship being one of beneficence (Donovan, 2000) in which the doctor, or health professional, exercises self-effacement. In the interaction with the patient, the needs, concerns, desires, and so on of the doctor are irrelevant at that point in time as the patient is given central stage. Therefore, the professionals as people in the portrait seem to be in the shadows.

As the portrait unfolds, the conversations or voices of the professionals come to the foreground and take centre stage. This reflects professional practice, which starts with information gathering and moves on to the formation of professional

judgements. We are see this in action and by following the development of the professional judgements chronologically with the professionals involved. An artist using oils will first cover the canvas with a primer on which to start to sketch and later paint with oils. I sense the introduction of the portrait serves a similar function to the primer, setting the scene and understanding of the process that follows. Without this base the finished picture would lack wholeness for the reader, or as in our oil painting, there would be parts of bare canvas visible.

Summary

This consideration of the tools used to produce the portrait has added and complemented the previous deliberations within the critical appreciation. Allowing this to come at the end of the critical appreciation is, I think, apt when I move from a close-up view of the portrait to an overall view of the whole thing. The previously hidden aspects in the portrait are revealed because of the earlier work.

Final Overview

In this critical appreciation I have sought to become aware of a deeper comprehension of my professional practice and to communicate this awareness to my readers. The work has meant an excavation of some things that were just below the surface and others that were buried much deeper. Those just beneath the surface, for example many of the theories in practice, could almost be seen within the portrait and just needed clarification and time to stop and acknowledge them. Others, such as the healing process, were not obviously visible, although the question was posed, and required more in-depth exploration to reveal them fully.

The critical appreciation is not an analysis or exhaustive critique of the literature. Rather, it is the practitioner exploring and delving deeper into their practice to better comprehend their practice and all of its complexities and, at times, seeming contradictions. The end or purpose of this is to extend their own and other professionals' practice, to value and appreciate the artistry in their own and others' practice. The aim is not to come up with some law or guidelines for others to adhere to. There are different levels at which this exploration takes place and therefore the

way in which the literature is used. This aspect is discussed in greater depth within the chapter on methodology.

At times, an aspect of practice may have deep personal meanings for that practitioner. It could be that their reflections are personally biased or adopt one viewpoint only. From a psychotherapeutic perspective this is one form of counter-transference when these feelings are reflecting the practitioner's own issues as opposed to the situation when they are reflecting the patient's issues. From the perspective of everyday practice the practitioner must be able to differentiate between these two aspects. If the feelings are originating from the patient's issues this gives valuable insights which can be employed therapeutically if appropriate. On the other hand if they are the practitioner's own issues then he or she will need to be aware of them and ensure they do not adversely affect the patient's treatment. Self-effacement, which I discussed in relation to the operation of the doctor-patient relationship, then needs to come into operation. This means that the practitioner puts aside their own needs to enable them to focus exclusively on those of their patient.

I believe that, provided the practitioner is aware of the possible limitations, this does not negate or invalidate their reflections. I would actually argue these reflections are vital for the development of their practice, and perhaps more pertinent if they are touching on personal areas that have often involved pain for the practitioner. In these reflections there are no right or wrong answers. We seek not to tell people how to do it, but rather provoke them to appreciate and extend their own practice. Professionals are not going to agree on everything. Their practice involves value and belief systems deeply embedded within each of them but impacting on their actions. If a practitioner was deeply opposed to another practitioner's reflections, he or she needs to consider whether these issues were reverberating with a painful but unrecognised issue within him or herself. This is a two-way process with obligations for the writer in sharing their thoughts and for the reader in considering them.

Pertinent issues came into view and developed within the critical appreciation. Professional practice came to the forefront as I drew to a conclusion. Therefore, I explore professional practice and the role of the professional in depth in the next chapter. I also came to the conclusion that this work is fundamental to appreciating

and furthering professional practice in all aspects. This includes individual and corporate practice.

CHAPTER 4: CRITICAL APPRECIATION OF THE PROFESSIONAL

INTRODUCTION

The key issue to emerge from this study and the reflections I engaged in was the precedence of professional practice. When I embarked on this piece of work, I sought to elucidate how an Elderly Mental Health team could ensure its practice was a needs-led service in relation to the individual patients. As I grappled with this issue, the study developed from an exploration of how to ascertain and describe an individual's needs to a focus on professional practice. The answer I concluded to my original question, resided in the practitioner being a professional and engaging in professional practice, rather than what they did or didn't do, or what procedures were followed. For these reasons, I devote a chapter to reflect on professional practice and why I believe this is the central issue both to this study and for practising professionals in the 21st century. These reflections arise from my own experience in practice, discussion with colleagues and relevant literature.

Firstly, I consider the definition of a professional and their profession. Secondly, I look at the current relationship of professions to society. Thirdly, I examine professional practice in some detail. The issue of artistry, which came to the fore in the study of practice I undertook, is a major theme.

AN UNDERSTANDING OF THE PROFESSION AND THE PROFESSIONAL

Prior to any consideration of professional practice and its development, we must determine what defines a profession.

Hallmarks of a Professional

Cruess and Cruess (1997) summarise the sociological literature on professionalism. They point out that the concept of professionalism evolved in Western culture largely with the advent of industrialisation, although its origins can be traced back to medieval times with the development of Guilds and Universities. They suggest that there is a distinction between the physician-healer and the physician-professional,

and that the healer was recognised within ancient societies, but the concept of the professional was not. Although I agree with this, I dispute the implicit assumption that professional practice was not occurring prior to its articulation. I believe the principles of professional practice and the professional were recognised but not articulated in our modern concepts. Indeed, I think the function has been present in many societies and implicitly intertwined with the healer, the priest, and the advocate. A consideration of the Hippocratic Oath demonstrates this in relation to the role of the healer. Interestingly, an examination of the draft revision of the Hippocratic Oath produced by the British Medical Association (BMA) (Hurwitz and Richardson 1997) mirrors the duties for professional practice set out by the General Medical Council (GMC 2001). This highlights that the roots for professional practice were evident in ancient Greek society and were already bound to the role of the healer.

To understand fully professional practice and the ideal of a profession, we must consider its history to avoid misconceptions. Carr (1995) emphasises the problems when a concept is examined solely in the present, whether from a philosophical or pragmatic viewpoint. Aristotle examined some of the principles from which our modern concepts of professions developed. Bios praktikos, or practice, was a 'life devoted to right living through the pursuit of the human good' (Carr 1995, p.67). There is immediately evident an emphasis on the moral aspect, perhaps something we often overlook when endeavouring to define a professional's role.

Aristotle distinguished between the concepts of poiesis and praxis. Poiesis broadly corresponds to our technical expertise and involves the technical knowledge (techne) to produce a specified object; to make something. This term was used when referring to craftsmen of his day, such as ship builders, and this concept can still be applied to skilled occupations, for instance electricians and plumbers. In contrast, praxis is not about making an object but achieving a morally worthwhile good, which involves doing rather than making.

> Indeed, *praxis* is different from *poiesis* precisely because discernment of the 'good' which constitutes its end is inseparable from a

> discernment of its mode of expression. 'Practice' is thus what we would call morally informed or morally committed action.
> (Carr 1995, p.68)

The 'good' is realised in the action and this end cannot be predetermined, unlike the craftsmen who knows the specifications of the object being made. The distinction illustrated by Carr is crucial in understanding the difference between these two concepts. He is also underlining that this is a morally informed action.

Beckett emphasises this moral aspect in his discussion of professional practice, and quotes Ross who eloquently illustrates this point further:

> Practical wisdom does produce an effect. Virtue, no doubt, makes us choose the right end to aim at, but practical wisdom makes us choose the right means. Practical wisdom, however, cannot exist independently of virtue. The power to attain one's end, be it good or bad, is not practical wisdom but cleverness. Let the right end be aimed at – and only virtue can ensure this – and cleverness becomes practical wisdom; let the wrong end be aimed at, and it becomes mere clever roguery.
> (Beckett 1996, p.137, quoting Ross 1923)

Cleverness, techniques or abilities to influence things are not sufficient. Yet, I think there is a danger of focusing on the 'cleverness' of the professional and ignoring or minimising their morality. Indeed, I believe this is one of the greatest flaws of evidence-based medicine and is one of the reasons for the growing dissatisfaction with it, which emerges when I discuss it with colleagues. This is also evident in medical education and particularly at undergraduate level there is questioning of a predominantly fact-based training both in the United States (Coles 1998; Donnie et al. 1998; Makoul and Curry 1998; Novack et al. 1999; Wear and Bickel 2000) and in Great Britain (Howe et al. 2002; Hurwitz and Vass 2002).

The practical wisdom of the professional resides both within them as individuals and within the profession collectively. The hallmark of a professional is practical

wisdom, which arises from the practice of a group of similar professionals. A professional does not and cannot exist in isolation. We learn within a body of professionals and we continue to develop through dialogue with other professionals. This dialogue can be both oral and written. Practice, or practical wisdom, develops from dialogue within that body of professionals.

Characteristics of a Professional

The principle of practical wisdom, and the tradition within which this wisdom arises and operates, is the underpinning foundation of professional practice. Practical wisdom defines a profession from an occupation. Other factors can be cited, for instance a specialised body of knowledge, but none of these can give a definition of a profession without some exception being evident. These factors appear to me as common characteristics that will often be true of a profession but not invariably, whereas practical wisdom is the distinguishing characteristic that must be present. This is given further credence within the literature. Writers (Cruess and Cruess 1997; Donovan 2000; Hafferty 2000; Moline 1986) appear to grapple with defining a profession and discuss many of the common characteristics, but find none of them wholly satisfactory. They then turn to the moral obligations of the professional to the individual with whom the professional is engaged with in society. This becomes a common theme and conclusion. Embedded within this, whether explicitly acknowledged or not, is the principle of practical wisdom.

As Cruess and Cruess (1997) illustrate, most of these characteristics developed within Western culture with the advent of industrialisation. They are a result of an agreement or contract with society, albeit largely implicit (Fish and Coles 1998 pp. 3-14; Moline 1986; Richardson 2001). Indeed, the need to acknowledge explicitly and renegotiate this contract is being recognised (Crawshaw et al. 1995; Smith 1998). This historical process could be considered as the socialisation of professions whereby society has sanctioned this role. This relationship with society is considered in more detail in the next section.

One of these characteristics is the specialised body of knowledge, which is not readily available to people outside the profession. In recent years, there has been an

explosion in information technology and the easy accessibility to information. This has resulted in considerable debate regarding the specialised body of knowledge that a profession claims to possess. One argument is that now this information is readily available to everyone the 'mystique' of the professional has gone. The specialised knowledge of the professional appears available to anyone who wishes to access it.

The flaw in this argument, however, is the equating of information with knowledge. The knowledge of the professional includes the factual element (information) and also includes skills, experience, finely honed intuition, expertise, moral awareness and artistry. All of these facets of knowledge inform deliberative judgement (Fish and Coles 1998, pp. 254-286), which is the hallmark of the professional. This deliberative judgement is broadly synonymous with practical wisdom. The knowledge of the professional fully understood in all of its complexity and variety is not readily available to those outside the profession. This knowledge encompasses far more than just factual information that could be downloaded from the internet.

Nevertheless, professionals have actively promoted an erroneous belief within society. They readily accept the technical-rational view of practice urged on them from both internal and external sources. Evidence-based medicine was initially accepted unquestionably and it still wields immense power within the medical profession. No wonder then that people have come to believe that medicine consists of knowing which is the right technical intervention, and then become disillusioned when there isn't one, or when the situation is too complex. Before society can understand the concept of a professional's knowledge, the profession must come to know the nature and depth of its knowledge. Then the profession must convey this intelligibly to those outside the profession. The professional world now realises that professional knowledge entails more than just technical expertise. Schon (1983) was a major proponent of this, followed by many others particularly in the field of education (Beckett 1996; Carr 1995; Claxton 2000; Eraut 1994). This is recognised in other professions including medicine (Fish 1998; Higgs and Titchen 2001; Sternberg and Horvath 1999; While and Attwood 2000).

Initially, a lot of work has concentrated on the tacit or not easily verbalised aspects of practice (Eraut 1994). This is often referred to as the 'know how' or intuitive aspects,

which we need to acknowledge and transmit to those entering the profession. There is also a growing awareness of the artistry present within professional practice and the necessity to find a means of exploring it (Fish 1998). All of this is vital to gain a full understanding of professional practice but, alone or together, these elements of knowledge would not constitute professional practice if they remained divorced from the moral perspective at the centre of practical wisdom. Indeed, without this perspective, knowledge becomes at best mere cleverness or at worst roguery. Carr (1995) reiterates this in his discussion of 'know how' in the Rylean sense, whereby a teacher may know how to do something competently, but this only becomes an educational practice when the 'know how' is employed as the best means to attain the good of the pupil. There is a moral disposition inherent in professional practice.

Autonomy of the professional is another attribute seen to characterise a profession. This is evident, although undergoing major rethinking, in most Western democracies. The same is not true in much of the non-English speaking world. In these countries, the concept of the professional developed alongside state regulation. The regulation of the professional is a core issue in the contract agreed between professions and society. Certainly, within our own society, the autonomy of the professional is a contentious issue and this debate is a topical political discussion. The aspect of autonomy, whether desirable or not, is not an essential component to define a profession.

Conclusion

I believe from my own experience of professional practice that the definition of a profession is rooted in the concept of 'bios praktikos' as defined by Aristotle. Despite all the debates, we return to the use of a specialised body of knowledge in the pursuit of a human good. Undoubtedly, the relationship with the society within which the professional operates will vary and change, but the core of a professional will not and can be found in its ancient roots.

SOCIETY AND THE PROFESSIONAL

The recognition of a group as a profession is dependent on an agreement with the society within which the professionals function. In considering the basis of the professional and the profession, I conclude that, even if professions ceased to be recognised by society, the role of the professional would continue. In ancient societies, we see evidence of professional practice through the operation of individual practitioners within a tradition of practice, but not the recognition of the professions as we understand them today. This is something that has arisen with the advent of industrialisation in our society. In her review of the history of professionalism within the USA, Stevens (2002) points out that this 'concept is context-dependent; we are all creatures of our environment' (p.358).

Cruess and Cruess (1997) put forward a strong argument that the crisis is located within the agreement between the professions and society rather than individual practitioners. Interestingly, one factor they cite as problematic to society is the emphasis on technology, given the current preoccupation with evidence-based medicine. Yet in my experience, many prominent medical professionals still promote the idea that if the ideal of evidence-based medicine was attained, then there would be no problems in the relationship with society at large.

The contract with society revolves around trustworthiness. Professionals are trusted to use their knowledge to the benefit of the individual and society, and if required, to put these interests above their own. In return, society has afforded them respect and relative autonomy.

Autonomy

Autonomy is evident in the large degree of self-regulation in both existing and new members of the profession. This is certainly one area where there is a crisis of confidence within and without the medical profession. One of the major criticisms is that the General Medical Council (GMC) and other similar bodies have not been accountable either to society or to the profession. The result has been greater external

controls being discussed and imposed. Autonomy is threatened by the degree of management control. This control is in part a response to the lack of accountability felt by society, and a political strategy to try and control spiralling health care costs. The danger is that the concerns of the manager can be diametrically opposed to those of the clinician. Leung (2000) points out that the manager's focus is rightly on fulfilling organisational objectives and using resources effectively. However, the clinician's focus is to identify and meet the individual's needs. These can align very well but invariably there are times when they definitely do not. Moline sums this up succinctly:

> Thus physicians are not to regard themselves simply as salaried employees of this or that institution, still less as uncritical instruments for the pursuit of its goals. They are expected to stand up for quality care for their patients and for the advancement of the art of medicine even if this makes life for administrators less pleasant.
> (Moline 1986, p.508)

This was written in the days of administrators rather than managers, when direct managerial control of the medical profession was more tenuous than now. Given the changes over the last decade, I would argue this statement is even more pertinent to the current medical practitioner. My prime responsibility to individual patients is something I feel, as a practitioner, I have to keep firmly in focus, as I am pulled more towards a managerial role. Interestingly, one of the questions asked at a senior doctor's appraisal is 'Are you aware of the goals and aims of this organisation?' I feel this implies that these goals and aims are expected automatically to be the doctor's because they are part of the organisation. But isn't the goal for any doctor first and foremost the best interests of each individual patient? Surely the aims, or business, of the organisation must always be secondary to this?

As a practitioner, I find autonomy is essential for allowing me the freedom to pursue the patient's best interests. However, this is not the same as operating in a closed shop and being unaccountable, which I think has been a justified criticism, certainly of the GMC. There is a real threat that autonomy is being lost in this country and certainly within the USA, with the pitfalls of the managed care system (Haavi

Morreim 2002). I am not advocating for doctors to be completely free agents or uninvolved with issues such as balancing the needs of the individual with finite resources. The doctor needs to be part of the management system but, at the same time, should be given the autonomy to be the patient's advocate, even if this entails being at odds with management. Doctors have an obligation to the individual patient who consults them and to society at large to speak out on issues that effect health. Sometimes, this brings them into conflict with managers and politicians but that is an integral part of their contract with society (Cruess and Cruess 1997; Moline 1986; Stevens 2002).

A comparison between the position of doctors in Britain and the USA reveals an interesting and important difference in the current relations with management. Stevens (2002) highlights this in her contribution to the conference on medical ethics in New York in 2000. The theme of these proceedings was professionalism. Reading the papers from this conference certainly demonstrates that colleagues there are facing similar difficulties. Stevens highlights that, within the USA, doctors have ended up in a position of conflict with management, whether private or public, and have become outsiders without an authoritative voice. In contrast, in Britain doctors have maintained a role and voice within the management structure, which means there is the opportunity to influence the organisation. Although the situation in Britain is at times far from ideal, I think it is preferable to that faced by colleagues in the USA, and is important to enable the fulfilment of doctors' responsibilities to their patients.

Trustworthiness and Accountability

For society to continue to allow professions a degree of autonomy, professionals must fulfil their side of the agreement. They are obliged to be trustworthy and yet this appears to be the very issue that is contentious within society today. In the third of her Reith lectures, O'Neill (2002) makes the point that society says it trusts less, through polls for instance, but actions suggest this isn't the case. Individuals still turn to the professionals for help in times of need. Nonetheless, society and the professions are struggling to demonstrate the worthiness of the trust being placed in professionals today.

Jackson (2001) examines the complex intertwining of truth and trust in relation to medicine and links this into the notion of patient autonomy, which has become a principle enshrined within modern thinking. This has led to the current government dictates to ensure all information is given to patients, whether they actually want it or not. The NHS Plan states that letters should be copied to patients and that consent must be informed consent, with every bit of possible information given. Jackson points out confusion inherent in this thinking. Firstly, there is a difference between telling a lie or actively deceiving, which are never justified, and withholding information for the patient's benefit. If a patient cannot cope with the information and communicates this to the doctor, is it really then in their best interests to force it on them? Of course, this does involve professional judgement and discretion, an issue Jackson emphasises. Secondly, trust arises from the belief that the doctor will act in your best interests not from having all the available information given to you. The doctor's knowledge is far more than mere facts; it is practical wisdom and that is what the patient is seeking. Latham discusses the authority of the doctor and why we accept this authority and concludes:

> The authority has, for reasons of superior wisdom, experience, or knowledge, privileged access to some body of knowledge; the subjects of authority, recognising that privileged access, agree to defer to the authority's judgment with regard to the proper interpretation of that body of knowledge in particular cases. An authority in the classical sense is thus an intermediary between his subjects and a body of knowledge to which his access is direct, theirs wholly vicarious. (Latham 2002, p.366)

Latham states that the authority patients give to the doctor, or the trust they place in them, is because they believe the doctor will use the specialised knowledge they have for the patients' good. The trust is not based on patients having the same knowledge; there is an acknowledgement that this would not be possible. The erroneous belief that the accumulation of more information for the individual patient will lead to an increase in trust for that individual, is reflected at a corporate level. O'Neill (2002) demonstrates its futility. In fact, I and my colleagues have found that requiring

professionals to concentrate on collecting information about our activities, often through the proliferation of mandatory audits, deflects our time and energies from caring for the individual patient and accomplishes the opposite.

Wolgast (1992) discusses the concept of the 'artificial person' within organisations. She argues that organisations and governments become the 'artificial person' acting on behalf of other people. The government acts on behalf of the citizens, the military on behalf of their country and the NHS on behalf of society. When people operate within these organisations they adopt a role they have agreed they will fulfil. The issues of responsibility and accountability, however, become complicated and far from clear.

A person adopting a role is problematic for the professional in particular. If you have a role, this tends to be seen as separate from you the individual, and in operation only within certain contexts. This is clearly in conflict with the idea of a life devoted to practice, as suggested by Aristotle, rather than something that is put aside when you go home. Also as Wolgast argues, the idea of a clear demarcation between the individual and their role is debatable; the two are intertwined. This is true whether we are considering a professional or not. There is a problem with responsibility. If you are just fulfilling a role on behalf of the organisation, then you could argue that you are not individually responsible for the consequences. This lies with the 'person' (organisation) on whose behalf you function. Nevertheless, each professional is personally responsible and accountable for his or her own actions, whether or not the professional acts independently or on behalf of an organisation. Indeed, professionals have a moral obligation to speak out if the organisation is preventing them from honouring their obligations.

Furthermore, when an organisation adopts the role of an 'artificial person', who accepts responsibility? In reality, a person with a concern can become frustrated trying to actually locate the artificial person. This is not surprising given that, in reality, they do not exist but are merely a product of our political system. Within the NHS there are prescribed procedures for formal complaints and the final responsibility lies with the Chief Executive. These procedures, however, are burdensome both to professionals and the complainant. I am unconvinced that the

real issues are addressed. Often I suspect that if practitioners within the organisation accepted responsibility within their sphere of influence, many of these formal complaints would not arise. When I talk to patients and their carers, frustrations often arise because no-one will actually accept responsibility, and the matter is passed continually to an elusive 'other person' or the 'artificial person'. If you acknowledge that, yes, it wasn't acceptable for their relative to be moved from ward to ward and you understand their feelings about this, even though practically you can't change the situation, usually this is all they want to hear and a formal complaint will not result. An individual has allowed the 'buck' to stop with them. I am constantly amazed at how generous patients and their carers are regarding the service's and professionals' shortcomings if professionals are open and accept the responsibility.

Although organisations must be accountable, we must be aware of the pitfalls inherent within organisational responsibility. Organisations are, after all, groups of individuals. Although I agree with the need for a no-blame culture within the NHS, to enable the organisation and individuals to reflect and learn from things that did not go well, we must not allow this to become confused with a no responsibility culture.

The Way Forward

In the light of this evidence can we conclude that professionals should retain their autonomy and be unaccountable? No; to continue to serve society as a professional, a measure of autonomy is vital but the professional and the profession must be held accountable. The problem lies in a misunderstanding of how to foster accountability. At the corporate level, O'Neill suggests we need to adopt an intelligent accountability. She describes this as letting go of the current myth that everything can be controlled and continually observed. There must be an acceptance that all things are not measurable. Instead, institutions should give an account of their activities and achievements to a group of individuals who have the expertise to judge whether these are acceptable or not. This comes down to a value judgement and would need to be open and communicated to the public.

At the individual level, practitioners must understand the basis of their practice in all its complexity and, at times, ambiguity (Fish and Coles 1998, pp. 28-53). We then

must learn to convey our practice to society (Fish 1998). Trustworthiness depends on the operation of practical wisdom, which arises from the moral commitment of the practitioner, not on the amassing of information. Within both Britain and the USA, there is a crisis in the relationship between society and the profession of medicine. To continue to operate effectively, medical professionals must understand the basis on which trustworthiness is credited to them and seek to account for this both on an individual and corporate level.

PROFESSIONAL PRACTICE

In the earlier sections, I considered the definition of a professional and their relationship to society. This included some discussion about professional practice. I now examine some aspects of practice in more depth to inform an understanding of the everyday practice of the practitioner and its continuing development.

Theory and Practice

I developed as a medical practitioner in a culture where there is an unquestionable assumption that theory is pre-eminent to practice. Once the relevant theory is learned or discovered then the right practice will follow. Therefore, if there is a problem in practice, the difficulty must lie within the practitioner not applying the theory correctly. This culture has been further extended and established with the growth of evidence-based medicine. However, one of the characteristics of real life practice is how messy, uncertain and unpredictable it is, mirroring Schon's (1983) analogy of the swampy lowlands. Mr Smith, who is referred to me today with Alzheimer's dementia, will be quite different from Mr Jones referred last week with the identical condition. Both may require the same technical intervention, for instance the prescription of a cognitive enhancing drug, but neither will react identically and predictably even with this. At the basic biological level, for example DNA, people are all unique and there is invariably a degree of unpredictability introduced. Therefore, because no two episodes of medical practice are identical, all practice is contextually based.

Formal theory, which seeks universal laws and generalisations, is important and needs to inform practice, but it is only one small part of it. Of equal importance to informing practice are theories in use (Eraut 1994) or informal theories (Usher et al. 1997). These are contextually based within the practice itself. For much of the time these theories can remain hidden from the practitioner, both because time to critically reflect is required for them to surface and because their value has not been acknowledged within the power bases of the professions. These theories in use form an integral part of deliberative judgement (Fish and Coles, 1998 pp. 254-286; de Cossart and Fish, 2005) or practical wisdom, which I have argued is the hallmark of a professional and their profession. Recognising and verbalising these theories enables the practitioner to appraise them both individually and collectively. This is acknowledged as a major component in reflective practice (Coles 1996; Day 1993; Schon 1983) and is very enlightening when the difference is evident between these and professionals' espoused theories. These are the theories professionals would say they were using within their practice.

Theories in use can have a specific context-bound application and can embody a principle of practice, often incorporating a particular value or belief. Considering the first of these in the critical appreciation of Elsie's portrait – the holistic perspective – it was conveyed largely through the visual imagery used by the practitioners, myself included. The actual visual imagery, the journey into uncharted land, portrayed the theories in use for this particular case and informed the deliberative judgements made. That part of the theory in use is highly specific to Elsie's case and not transferable. However, the other part of the theory in use is how valuable visual imagery is to the practitioner in fostering a holistic perspective. That principle is readily transferable to other cases and arose directly from theorising from practice. Since undertaking this work, I have given myself permission to attend to the pictures that come into my mind when working with patients. I value that part of my practice and I can explain why to other practitioners. My practice has developed from bringing the theory in use to the surface.

There is no doubt that the theories in use within Elsie's case informed the deliberative judgements made by the practitioners involved. I would strongly suggest that if these theories were not in operation, then the team would not have successfully

met Elsie's needs. This does not mean that practitioners should discard formal theory. I would be an odd doctor if I didn't know how the medications I use are supposed to work and how the body reacts. But this is only one part that informs my practice. The problem is as a profession, and within society, we have come to perceive this as the only knowledge base informing practice. All of us, including the public, need to achieve a balance whereby different forms of knowledge are recognised and valued.

The false split between theory and practice becomes evident in the previous discussion. Schon, who in his seminal works challenged this dichotomy, explains why this has arisen:

> Technical Rationality is the heritage of Positivism, the powerful philosophical doctrine that grew up in the nineteenth century as an account of the rise of science and technology and as a social movement aimed at applying the achievements of science and technology to the well-being of mankind.
> (Schon 1983, p.31)

He makes the connection between where we are today with the pre-eminence of a technical-rational perspective, to its evolution and links with society. This thinking, or philosophy, developed in Western societies alongside the industrial revolution. Science and technology brought enormous benefits to society. There has been a down side to this too, which society is becoming more aware of but which is beyond the scope of this work. In relation to medicine, a transition from a mainly folklore to a scientific-based practice occurred. Nobody would discount the huge significance of this and the benefits it produced. Not surprisingly, this philosophy became firmly linked to the notion of human benefit and development. A rationale was established that all human problems and suffering would be conquerable once science developed to the right level to provide the answer. As a consequence, this came to be accepted as the only 'truth' and society needed to be set free from all other erroneous contenders, for instance 'religion, mysticism and metaphysics' (Schon 1983, p.32).

A belief in science and technology developed, which replaced earlier beliefs. This is actually part of a belief system within society, whether people explicitly or implicitly

adhere to it. A belief is a more deeply held construct than knowledge, and consequently is much more resistant to revision. Fish and Coles (1998 pp. 305-306) illustrate this well in their analogy of the iceberg of practice. Knowledge is at the surface and is easily accessible, whereas beliefs and values are at the base and are difficult to access.

A related, but separate factor is the issue of power relations. The technical-rational view is dominant in society and has greater credence. As a result, the rewards for those who expound it are greater, both in terms of influence and prestige. Frequently this increases the financial rewards. Certainly within medicine, academic recognition and reward traditionally go together. Funding for research, which will foster the individual's standing and can have financial benefits to the service, is firmly based in the technical-rational view of medicine. Research and researchers based in another world-view will rarely attract equivalent acclaim and are likely to be viewed in a derogatory manner. I have personally experienced this in regards to this work. Rather than reflecting the true value or otherwise of the respective research, this distinction frequently reflects more about the power relations existing within medicine. Both of these elements have contributed to the theory practice divide we now confront.

The foregoing discussion challenges the traditional theory practice divide from reflection on everyday practice and recent developments of thinking in the literature. The consequence of this view was examined in the light of its historical development and the influence it continues to exert on the medical profession. I now take a step further and consider the issue of artistry within practice, which is perhaps an even more contested concept.

Artistry

The debate in medicine about the role of art and science has continued over many years. Often when people lament a lack of human qualities within the doctor, they equate this with a loss of the art of medicine. This is reflected in Engel's paper on 'The Care of the Patient: Art or Science' in 1977. He argued that the human side of medicine is as amenable to scientific endeavour as the more technical aspects. He approaches this through illustrations of the use of psychoanalytic concepts, pointing

out the error of the assumption that a concept is only valid if it is quantifiable. The debate is mirrored in other works, including Frank (1995), Lown (1999) and Kleinman (1988). All of them advocate a wider consideration of healing and the healer as opposed to a narrow technical-based view.

Although this is a valid and important discussion for the medical profession, the area I propose to discuss is the use of artistry within professional practice. This is just as true within a 'technical' intervention, for example an operation, as in a more 'human-based' intervention. The crux of the matter is to comprehend that the professional, in this instance the doctor, is an artist not a technician. Understanding this then leads to implications for the exploration of practice, which will be discussed more fully in the chapter on methodology. Schon (1983) examines the operation of the technical-rational view of practice and its consequences, one of which is that professionals are technicians. He then explains why this world-view is inadequate, in either informing or understanding the real practice world in which professionals function. He shows that technical-rational knowledge is just one of many other forms of knowledge that the professional uses. He poses a challenge:

> Let us search, instead, for an epistemology of practice implicit in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness, and value conflict. (Schon 1983, p.49)

By stating 'some practitioners', he is emphasising that professionals may or may not operate artistically. I would question whether operating on a purely technical level can indeed qualify as being professional given the earlier discussion about practical wisdom. The very situations he highlights of 'uncertainty, instability, uniqueness, and value conflict' are not amenable to a technical-rational answer. His challenge to find an understanding or expression for these artistic and intuitive processes arises from the evidence that professionals employ these modes of operation, but rarely recognise them, and if they are aware of them, certainly can't explain them. However, I do not feel that the full extent of the artistic mode of operation in professional practice is explored. He mainly relates this to the creativity seen in the process of reflection in action, which links to the later discussions on procedural or process knowledge. Eraut

(1994) expands these concepts and considers the various forms of knowledge that the practitioner uses. He specifically concentrates on three broad areas: propositional knowledge, personal knowledge and process knowledge. He alludes to other forms related to the arts but doesn't develop this further.

One of the reasons why there is an acceptance of the emerging idea of professional artistry is that it resonates with practitioners' experience. In an interview with a consultant in palliative care, we were discussing the issue of how to cope with patients' unrealistic expectations. She related to me several specific examples, and then offered this insight:

> I think that's why it's not about teaching techniques, it's about developing that sensitivity I think within each professional um just being alert to cues really and you know I suppose that's the art I think rather than the science point of view because you don't ever know do you? With every person it's so different and sometimes you're working on your gut instinct. I realise that it's our training that informs that instinct but it's nevertheless something you feel rather than something you necessarily see or hear.

Gawande (2002) echoes these thoughts in his reflections as a resident in surgery. He looks specifically at medicine's 'mysteries' that certainly can't be explained by a technical-rational view of practice. Surgery is perhaps a speciality where the concept of artistry might not immediately spring to mind. Elsie's portrait illustrated artistry on many levels, for example the team's ability to attune to her unspoken communications and communicate their care back to her. This was crucial to the healing process for her.

Professional artistry has not been well developed in the literature because of the limited means employed. An attempt is made to use rational methods, whereby a phenomenon is described and its component parts identified. This is a reductionist approach and the means that professionals have grown accustomed to relying on. The progress made in understanding the different forms of knowledge are paramount and are an important part of professional artistry, but there still needs to be a further step

to fully appreciate this phenomenon. Andresen and Fredericks (2001) grapple with this very issue, asking if artistry within professional practice can be given a name, and warn against trying to reduce it to its component parts. Fish (1998) has proposed the means to explore this artistry within professional practice, which is why I have chosen to adopt the artistic/holistic paradigm in this study.

Conclusion

The consideration of professional practice has highlighted both its complexity and multifaceted nature. I have argued, from my reflections on my experience of practice and the literature I have reviewed, that the allusion to a technical-rational basis for professional practice is false and suggested the alternative view of professional artistry.

SUMMARY

In this chapter I discussed the foundations of professional practice and argued that they are rooted firmly in a moral basis that operates through practical wisdom. This practical wisdom I believe is fundamental to the aim of being a needs-led service, which was my original inquiry at the conception of this study. The consideration of professional practice emerged as a central issue as I reflected on Elsie's episode of care with the EMH team and sought to understand the basis of my own professional judgements.

CHAPTER 5: REFLECTION ON THE RESEARCH PROCESS

INTRODUCTION

In this chapter, I reflect on the research process itself. This can be seen as the outer circle of reflection in the picture I suggested at the beginning of this work. These considerations are central to realising my research aim, which is:

To determine how research can be meaningful and relevant to practitioners.

I start by exploring the research/audit trail, which is vital both to establish the trustworthiness of the work and to illustrate the development of my research practice. This chapter explains the evolution of my thinking in more detail and the realisation of my research aim. Following this, I consider the issues about practitioner research, also known as insider research, and the implications for ongoing professional development.

RESEARCH/AUDIT TRAIL

In this section, I relate in some detail how this study evolved and the process of reflection that occurred within me, the researcher. There are three main parts to this. The first explains the original steps taken in the conception of the study. The second considers the initial work, including the fieldwork, up to submission for transfer to a PhD. This was an important landmark in the evolution of the study, and the junction at which its final form began to be clearly visible. The final section explores the comprehension of the research focus and format of this work.

The Initial Steps

I am a psychiatrist with a special interest in psychodynamic psychotherapy. This promotes a view of the person as an individual, within the context of their unique circumstances, and emphasises their perception or view of reality. This form of psychotherapy, par excellence, demonstrates what many would refer to as the 'art of medicine'. I was always aware that psychotherapy sat uncomfortably with the

prevailing view of science within medicine, which demands measurable outcomes to prove effectiveness. I observed the often frantic search for rating scales to fulfil this demand and yet these scales lost the very essence of what they were supposed to be measuring. As far back as 1977, Engel quoted Novey who discussed this issue, although specifically in relation to psychoanalysis. Novey pointed out that a kind of arrogance had crept in whereby, if a body of knowledge cannot be demonstrated by quantifiable means, then that knowledge is considered worthless. In addition, reducing many variables to a measurable value actually renders them valueless. These points are equally true in all areas of medicine. Golby and Parrott (1999) echo this in their discussion of educational research, showing that this attitude is not confined to medicine.

The idea for this research arose from an away day I attended with the EMH team, shortly after joining them as a Senior Registrar. The purpose of the day was to consider the aims of the team, and in particular how to ensure the team was a needs-led service. A lot of the discussion focused on determining patients' needs, rather than fitting them into the services available. The outside facilitator suggested that the team considered mapping patients' journeys through the service. Certainly at this juncture in time I was looking for a suitable research project. I had few expectations of its worth, either its relevance clinically or its benefits to me as a practitioner, given my previous experiences. My initial thoughts were to conduct a survey of some of the patients on admission to the day hospital to determine their needs and then to map them through the service to see if these needs were met. Following on from the workshop, I was interested in what a truly needs-led service was, and began to consider this topic in more detail. The first requirement for this type of service would be a clear understanding of what needs there were before you could start to meet them and led to my initial review of the literature on this topic.

A need is recognised when there is a requirement, a necessity, a lack of something, or a state of want. Yet this concept becomes ambiguous when concrete situations are considered and a precise definition of a person's needs becomes elusive. In the present climate, health professionals are expected to adhere to an objective definition of needs, which they should then be able to quantify. I noticed that even authors who proposed an objective theory of basic human needs (Doyal and Gough 1984; Tracy

1986) only manage this at a very abstract level. When considering more tangible situations, even they then had to start incorporating social and cultural aspects. As a clinician, I deal with real everyday situations and not abstractions.

Despite the difficulties in measuring precise needs, there is pressure to develop needs assessments. These are seen as an important tool for decision-making in human services (McKillip 1987), to enable the appropriate targeting of scarce resources. This highlights the issue of rationing and, I would argue, why there has been a push to define and measure needs so that a rationale for rationing can be easily provided. Webb and Wistow (1986) suggest that welfare state planning has changed from being based on a 'pure doctrine of need', to planning within a doctrine of scarcity. There is no doubt for me as a practitioner that this is increasingly true in my everyday practice. Maynard (1986) argues that rationing is a reality, but that it often remains implicit and confused, and Cassel (1994) sounds a warning that it will impact on the elderly the most.

In contrast *The National Health Service and Community Care Act* (DOH 1990) emphasises that services must be tailored to meet the individual's needs. This has resulted in much discussion within medicine about how to demonstrate that services are meeting this directive. Particularly in psychiatry, there was an attempt to develop standardised tools to assess and measure individual needs. The two nationally recognised tools are the Medical Research Council (MRC) Needs for Care Assessment (1987) and the Camberwell Assessment of Need (Phelan et al. 1995). The latter is adapted for use with the elderly.

In the process of devising standardised instruments to measure or quantify an individual's needs, a process of simplification takes place. The authors of the MRC Needs for Care Assessment recognise that needs are determined on the basis of a value system. They base theirs on the notion of ideal practice, which they believe is similar to the decision-making process occurring within a clinical team. I echo Marshall's (1994, p.35) comment that 'The model is clearly an oversimplification of a complex process'. In addition, no evidence was offered to support this model. I suggest that this would only be amenable to a qualitative approach, not a quantitative approach, and may be the reason this was overlooked.

There is recognition in the literature of the complexities inherent in assessing health needs (Mangen and Brewin 1991; Holloway 1994; Slade, 1994; Thornicroft 1995). Among the many aspects acknowledged are the subjective perception of need and the interaction of wants/demands; the value systems influencing decisions; the many and valid differing perspectives; and the influence of cultural context. Despite acknowledging these issues and on one level trying to incorporate them, there remains an over-riding concern to develop standardised instruments, which by their nature cannot truly recognise, let alone do justice, to these factors. I began to realise that many of these factors and issues, in relation to needs assessment, can only be explored in depth using a qualitative approach, and this has largely been neglected in medicine. I also wanted to capture something of the process whereby an individual's needs are met as they interact with practitioners. This is an individualised process, yet as a practitioner I know when it goes well, but I couldn't put this into words or explain it. Even at this early stage, I had a vague sense of seeking something of beauty; by this I mean a sense of satisfaction within the practitioner, in the same way artists feel when they create a new work. These initial reflections and deliberations led to the original fieldwork.

The First Stage of the Journey

Initially I set out to develop a meaningful means of ascertaining a patient's needs, both when they presented and over time as things progressed in their encounter with the EMH team. The preceding deliberations had already convinced me that the traditional positivist paradigm approach adopted within medicine was inadequate for this task. I therefore adopted a qualitative approach. My initial research questions were:

1. What are the needs of patients when they present to an EMH team?
2. How can these be identified, taking into account the multiple perspectives?
3. How does the presence of the clinician/researcher influence the perception of need?
4. What influences different perceptions of need?

5. What is the process of needs assessment that occurs in everyday clinical practice?
6. How do these needs change over time and what influences these changes?
7. How transferable will the results be to other patients presenting to the EMH team?

At this point I wrestled with the realisation that there were other ways of understanding and carrying out scientific research. Initially, I assumed this just required the use of alternative methods i.e. qualitative rather than quantitative. Gradually I appreciated the importance of the methodology adopted, as opposed to the methods, because this encompasses a world-view, beliefs and values. This led me to adopt the constructivist paradigm, also known as the interpretative paradigm.

Guba and Lincoln (1989) outline that the constructivist paradigm acknowledges the existence of multiple socially-constructed realities. It employs an inductive process to allow the emergence of a joint construction of reality. From my reflections as a practitioner, when working with an individual patient there are certainly multiple ways of seeing things. Not only can the patient's view of things differ from mine, but also the other professionals within the multidisciplinary team may have different ways of seeing things. To proceed, there has to be a joint construction of reality, or agreed view. This, therefore, appeared to be a good basis on which to design the work. I also noted the comments of other authors (Denzin and Lincoln 1998; Holloway 1997; Patton 1990) who argue that this paradigm provides a good means for understanding human experiences.

Denzin (1989, p.4) states 'each theory demands and produces a special view of the research act'. The theory underpinning research is fundamental to the research act or methods that are employed. However, my theory of research was not yet fully formed and although the adoption of the constructivist paradigm was instrumental to the development of my research practice, including the theory underpinning it, it was just the next step.

Fieldwork

I adopted a case study approach, which occurred on two levels. Firstly, individual case studies of patients, and secondly, a case study of the EMH team. The individual cases I selected were of the 'particular' not the 'unique' (Golby 1994), thereby ensuring they related to other cases presenting to the EMH team. This meant that insights gained from these studies could be utilised in a wider arena. Similarly, the EMH team was 'typical' in its composition and functioning compared with EMH teams in general.

The EMH team broadly deals with two main groups of patients. One group involves patients with a functional illness, usually depression. The other group consists of patients with organic illnesses, mainly dementias. I therefore selected three patients who, on the basis of their GP referral, had a probable depressive illness and three patients who had a probable dementia.

Data collection was through unstructured interviews (Coles and Mountford 1988; Britten 1995), with a focus on the needs of the patient. These were audio taped with each interviewee's permission and later transcribed by the researcher. Those interviewed were the patient and a carer, if possible, and any member of the multidisciplinary team who was involved with the patient. They took place at intervals over a period of 18 months, or less if the patient was discharged or died. I also conducted further interviews with members of the EMH team to compile a case study of the team.

The sampling was purposeful (Holloway and Wheeler 1996). This means further sampling was directed by the ongoing data collection and concurrent analysis. For instance, one theme that arose was dealing with patients' and carers' unrealistic expectations. This was highlighted in the first case study of Mr Z., no matter what the team offered to this man's wife it was not acceptable. His wife stated quite clearly that what she wanted was her husband 'back the way he used to be'. Mr Z. had vascular dementia and clearly would not get better. The team worked hard to try and help his wife to come to terms with this, in my experience as a practitioner often

patients and carers are able to come to terms with these issues given time and support. However, Mr Z's wife was not able to do this and her unrealistic expectation, that Mr Z. could be cured, led to her being resentful to the team and undermining some of their work with him. On one occasion a physiotherapist visited him at home because of repeated falls, she suggested that he used a zimmer frame and that loose rugs in the home were removed. His wife refused both of these suggestions but still wanted her husband to stop falling at home. This particular case underlined how a patient or carer may have unrealistic expectations, in this instance a cure for dementia, and how this influences their interaction with the professionals. This is not uncommon in my experience or in the experience of the other practitioners with whom I work.

As a consequence of this theme emerging, I arranged a research interview with a consultant in palliative care where this might be expected to be a particular issue. She had similar experiences and discussed the importance of addressing these unrealistic expectations with her patients before being able to embark on meaningful work with them. This was part of the purposeful sampling, this interview arising from the analysis of the previous interviews.

The initial case studies were:

Patients	**Diagnosis**	**No. of Interviews**
Mr Z	Vascular Dementia	11
Mrs Y	Vascular Dementia	15
Mrs X	Depression with Agoraphobia	7
Miss T	Alzheimer's Dementia	8
Mrs S	Agitated Depression	9

The transcribed interviews were coded according to the themes that emerged. These themes were then compared within the case and across the cases. From this, a composite picture of the individual needs of each participant was formulated, which gave rise to the individual case studies. To enable the case study of the EMH team, three focus groups (Fontana and Frey 1998; Holloway 1997; Najman et al 1992; Patton 1990) were conducted with the team. These groups were audio taped, transcribed and analysed in the same manner as the individual interviews.

Ethical Considerations

This issue was addressed at the outset of the study and no work can morally disregard this aspect (Holloway 1997; Punch 1998). Three pertinent issues in this context that must be considered are:

1. The therapeutic benefit of the research;
2. Informed consent and voluntary participation;
3. Protecting the participants from harm.

This discussion of ethical issues covers a broader base of fieldwork than is evident in this thesis. This is because the final study arose from the development of earlier fieldwork. In the original fieldwork, six patients were interviewed at intervals during the course of their contact with the EMH team. They included some patients with dementia, which gave rise to certain ethical predicaments.

The study involved patient and staff participation within a Health Care Trust in the South of England, and ethical approval for this was obtained from the local ethics committee. Research conducted in a medical setting must demonstrate a therapeutic benefit as opposed to solely seeking scientific knowledge. In undertaking a research degree, there could be a danger to overlook this important aspect. Many patients and staff agree to participate in a study, even when it entails some discomfort, if it occurs in the context of the common good. Undoubtedly, a study of this nature is less clear-cut in terms of the possible therapeutic benefits than a drug trial with a new

medication. The benefit of this work, however, is the continuing development of practitioners who will then be better equipped to serve the patients. I suggest that the impact of work like this can at least be of potential benefit to patients.

Informed consent was a key issue both with the patients and the staff involved. Firstly, the patients are vulnerable because of the researcher's position as a doctor and association with those providing their care, as well as from the effects of their psychiatric illness. These issues must be addressed at all times and will vary over time. Capron (1999) discusses these dilemmas with psychiatric patients who are acutely distressed, and several authors consider this with reference to people with dementia (Berghmans and Ter Meulen 1995; Proctor 1995; Kitwood 1995). A diagnosis of dementia does not in itself mean that a person loses the capacity to consent. The ability to give consent is also contingent on the matter in hand. Therefore, a person may be able to give consent to move into residential care, but unable to consent to a complex medical treatment, for instance chemotherapy. Much of my everyday practice as an Old Age Psychiatrist is involved with assessing peoples' capacity to make decisions, including consent.

When people with dementia were approached, I ensured that carers were informed and present if possible during any interviews. At the beginning of all contacts, consent was reassessed, regardless of whether the patient had dementia or not. Initial contact was made by telephone and the study explained; if the person consented, an appointment was then agreed. This allowed time for people to consider the commitment further before meeting me. Letters (see appendix 1) explaining the study were given to all participants and their carers, which included a contact number for any queries. The researcher stressed the right for anyone to withdraw from the study at any point without needing to give an explanation, and that this would not prejudice their care in any way. The patients were approached with the consent of their GP and the Consultant Psychiatrist involved in their care.

The patients knew that I was a doctor but I stressed that I was not involved in their care. From the outset, I was clear that firstly I was a clinician, and secondly a researcher. Therefore, if there was an urgent clinical need I would give attention to this, regardless of any effects this might have on the research. In one instance, I

needed to arrange for the patient's GP to visit, because the lady was physically unwell when I visited her.

Voluntary participation was ensured with staff members. The study was explained to the whole team through an educational meeting where feedback was encouraged. Prior to each interview, willingness to continue was checked with each person, and an undertaking given that anything they disclosed but did not want included in the study would be respected. When conducting in-depth interviews, people can often share private and intimate aspects of themselves (Patton 1990, pp.353-357) and it is essential for them to feel protected from any harm. Certainly in one interview a practitioner spoke at length to me about her own experience of a serious illness and how this had impacted her.

The interviews were tape recorded with each participant's agreement. The tapes were kept securely and only listened to and transcribed by myself. They will be erased when the work is completed. Confidentiality and anonymity have been maintained in the write up and pseudonyms have been employed where appropriate.

I was aware throughout the study of my close relationship to the team I was working with, and indeed I am now a consultant with them. I sensed that they joined with me in this as a piece of collaborative inquiry. Many of them reported to me how much they enjoyed the opportunities to reflect together on working practices. However, I was aware of the need to constantly monitor my relationship with them and not to put anyone under pressure because of this.

Ethical considerations are at the centre of any research endeavour and evolve as the study progresses. This was certainly true in this piece of work and I attempted to outline this in the earlier discussion. I return again to the issue of ethics, particularly in relation to work within the artistic/holistic paradigm, in chapter six.

EMERGING RESULTS AND REFLECIONS

The case studies began to demonstrate an alternative means for needs assessment. There was no doubt in my own mind, and from discussion with fellow practitioners,

that this assessment of needs was more meaningful and relevant clinically than the needs assessment tools available. See appendix 2 for a sample of one of these case studies. In addition, a theory of needs assessment within the clinical encounter began to emerge, and this was refined as further sampling took place (appendix 3). There were also pertinent themes arising across the cases I explored further.

All of this was refreshingly different to my previous experiences of research. The work was meaningful and, indeed, I could have completed it for my final thesis. But, I was still frustratingly aware that this work, though good, was not capturing the essence of the encounter between the patient and the professional; in other words, professional practice. I came to realise in reflection with my supervisors that I was seeking a means to both express and explore my professional practice. Therefore, I turned to consider the artistic/holistic paradigm, which Fish (1998) was beginning to articulate.

A Change of Direction

This change occurred at the point of transfer from MPhil to PhD and was one of the pivotal discussion points during this. I sought a means, or methodology, that recognised and explored all aspects of professional practice and in particular the artistry. As a practitioner, I came to realise the importance of artistry in my practice and was the factor that determined when an episode of practice went well and when I knew that I had truly met the patient's needs. The functioning of artistry is the key to being a needs-led service for each individual who presents to us.

Professionals grasp the needs of the individual through their ability to read the situation, emphasised by Fish (1998) in her discussion of artistry. The reading of the situation is not a one off, but an ongoing process throughout the episode of care. The practitioner remains aware of changes, including subtle ones, in the patient's needs. Schon (1983) talks of professionals engaging in an ongoing conversation with the situation. In the portrait of Elsie, some of those conversations were made explicit. There were also times when they admitted to uncertainty or not knowing. For instance, the doctor who assessed Elsie picked up she was angry with him and her GP, but initially was unsure why. He took time to reflect on this and then used his

tentative conclusions to offer Elsie an inpatient admission, which was a turning point for her. Fish sums this up well in her description of the operation of artistry in practice:

> The emphasis on what is known should not be allowed to mask from us the extent of our uncertainties, and the need to use them – in combination with intuition, sensitivity, imagination and creativity – to work on the problem.
>
> (Fish 1998, p.24)

This demonstrates the processes occurring in the artistry endemic to professional practice and was seen in the interaction with Elsie. Practitioners use their intuition, imagination and work creatively. Professional judgement is complex and cannot be reduced to a set of procedural guidelines because each situation encountered is unique. Therefore, in exploring and developing the artistry within professional practice, it evaluates how well our current practice is needs-led and demonstrates ways in which this could be enhanced. In other words, this was the means to answer my original research questions.

Fish (1998) proposed the artistic/holistic paradigm, which offered me the means to explore the artistry in professional practice. The rationale for my decision and adoption of this paradigm is presented in chapter one. I purposely located this information at the beginning of the dissertation to enable the reader to appreciate the portrait and critical appreciation of professional practice. This change of focus took place at the point of transfer to PhD.

Other important contributions to the development of this study were conversations with my husband who is an artist. They helped me to understand the artist's perception of their work and its creation, and emphasise the relevance of the personal life of the practitioner.

As the study neared completion and I began to draft the thesis, I saw the whole of this work rather than the disjointed pieces of it. Reflection on the whole of the study

enabled me to appreciate that primarily I was researching my own research practice. I also appreciated that this was truly practitioner and educational research.

INSIDER PRACTITIONER RESEARCH AND EDUCATIONAL RESEARCH

The full realisation of this aspect of this work occurred as I neared its completion. Using the analogy of the artist, as the portrait progressed the final form began to emerge as I stepped back to view it in its entirety.

In this work, I research my own practice on several levels. Firstly, I inquired into my clinical practice and the judgements formed within this. This centred on the episode of practice from which the portrait emerged. This is the level at which my original research questions were primarily located. Secondly, I moved out from this centre and inquired into issues about my professional practice in general, initiated by reflections on my clinical practice. Thirdly, as the thesis took shape, I realised I was researching my research practice. In fact, this was my primary aim and was the question I was trying to comprehend without realising it. Both Fish (1998) and Golby and Parrott (1999) emphasise that, in this type of research, the end cannot be known in advance. The questions will emerge as the research proceeds, and indeed are unlikely to be clear until the end. This has certainly been my experience.

Throughout, I have been researching my own practice, albeit in collaboration with other practitioners, and with implications for other practitioners. Therefore, this is insider practitioner research. There were many dilemmas inherent in this due to the developmental nature of this work and I will focus on these in my final reflections in chapter ten. Schon writes:

> When someone reflects-in-action, he becomes a researcher in the practice context. He is not dependent on the categories of established theory and technique, but constructs a new theory of the unique case. His inquiry is not limited to a deliberation about means which depends on a prior agreement about ends. He does not keep means and ends separate, but defines them interactively as he frames a problematic situation. He does not separate thinking from doing, ratiocinating his

> way to a decision which he must later convert to action. Because his experimenting is a kind of action, implementation is built into his inquiry.
> (Schon 1983, p.68)

I include this somewhat lengthy quotation because Schon captures so well what the research process was in this study. It is a reflection-in-action of research practice. The end certainly was not conceived until the end; the problematic situation required framing and repeated adjustments to that framing. Thinking and action proceeded together. There were cycles of reflection. Implementing the use of the artistic/holistic paradigm was experimental and part of the inquiry. The case was unique, in that I am unique as an individual practitioner, but equally it is of the particular in the sense that Golby and Parrot (1999) expound. I am a particular example of a kind of practitioner and therefore my journey has relevance to all those of that kind and also to practitioners in general.

This insider practitioner research is a practical enquiry in the tradition of Aristotle's classification (Fish and Coles 1998, pp.54-74). This form of enquiry is in contrast to Aristotle's 'theoretical enquiry', which seeks new theory and would equate to most of our scientific research. Practical enquiry is practice based and incorporates all aspects of practice, including the moral aspect. The practitioners themselves undertake practical enquiry. The aim is to further phronesis, or practical wisdom, and thereby refine or develop practice. As I have argued earlier, this is where professional judgement is located and is the hallmark of a professional. This is well articulated by Fish and Coles:

> This 'practical enquiry' involves engaging those who are involved in enquiry into their *own* practice in a wider practical discourse, the processes of which are calculated to open up greater understanding rather than designed to discover new knowledge, and the results of practical enquiry are not in the *application* to practice of *other peoples'* ideas but the refinement and development of one's own.
> (Fish and Coles 1998, p.62)

This leads to the development of the practitioner's practice, and is therefore educational inquiry or research. An important point they make is that this inquiry into the practitioner's practice opens up a wider discourse. This can be through the use of relevant literature and/or in debate with fellow practitioners. It relates to the traditions within which the practitioner practices and therefore can contribute to the development and refinement of these. The impact goes beyond the individual practitioner's practice and can contribute to other practitioners' practice and potentially to that of the whole profession.

Finally, I make the point that this is indeed educational research. It is both about education and is educational. I take the four criteria for educational research set out by Golby and Parrott (1999, pp. 60-64) as the guiding principles in this. Firstly, the research must be about education. This study is about the process of learning for the practitioner and has implications for education right from the initial stages until leaving the profession. It is, in a real sense, about continuing professional development, an important educational topic for all professionals.

Secondly, the research must be of practical educational benefit. New understanding of practice and its development is sought. The practical educational benefit is in demonstrating a new approach to continuing professional development and, importantly, research practice. This work demonstrates how research practice can be harnessed in the service of the learner.

Thirdly, the research must be useful and intelligible to those being researched. This can be considered on two levels. The first is with the practitioners who collaborated in this work. Throughout the interviews and focus groups, the feedback from other practitioners was very positive. Many commented that they valued the time to be able to reflect on their own practice, and saw this as valuable time. On the other level, I have had opportunities to present this work to other practitioners, including disciplines other than medicine, where it has been well received and initiated thoughtful discussions. In a sense, all practitioners are included in my research.

Fourthly, the research must be educational for those who conduct it. There is no doubt that I have developed in many areas through this research. It has been a long

and, at times, frustrating journey, but one that has been well worth undertaking. It has far reaching effects for my professional practice, including my research and teaching with students and trainees.

In concluding this section, I finish with a quotation from Fish and Coles:

> Primarily it enables practitioners to see their practice anew, to recognise and articulate its complexities and the contestable notions and values that lie at its heart, and thus to learn to refine those things which can be developed and live with those things which cannot. (Fish and Coles 1998, p.60)

FINAL REFLECTIONS

This chapter, as I stated earlier, is part of the outer circle of reflection within this work. In line with the artistic/holistic paradigm, the work up to this chapter is the portrait of my research practice. This chapter and the following chapters are the critical appreciation of that portrait. I have endeavoured to open up some of the reflections that occurred and have related these to the wider traditions and practices of research. A debate has taken place within the literature and behind the scenes with my supervisors, who are fellow research practitioners.

CHAPTER 6: METHODOLOGY AS AN EMERGING RESULT OF THIS RESEARCH – THE PORTRAIT OF PRACTICE

INTRODUCTION

In this and the following chapter I discuss and critique the methodology in detail. As I have outlined both in chapters one and five, this is a case study of me, the practitioner, seeking to find a way of researching my own practice. Therefore, the methodology and its practical outworking are in a real sense the results of this research. These results are the product of the outer circle of reflection I spoke of in chapter one.

Fish (1998), in outlining the artistic/holistic paradigm, emphasised that the ends cannot be known until the end is reached, in the same way artists do not fully know the picture until they finish. This process is an artistic endeavour and quite distinct from the more familiar forms of enquiry within the positivist, interpretive or critical paradigms. The research process I have presented in this work is itself a portrait. This illustrates the journey that occurred from the first ideas for the study to the final form, and this final form is quite different from the initial appearance of this work. The earlier sketches, which I outlined in chapter five, were instrumental in the creation of the final portrait. As the portrait took shape it was reworked until its final form was clear. Indeed, through this reworking, I came to recognise the larger portrait I had created of my own research practice within which the portrait of clinical practice was embedded.

The discussion of this portrait which now follows is a critical commentary on it. Up until this point I have endeavoured to convey the research practice through its portrait; now I am adopting the role of the critic to appraise the portrait and through it the practice itself. Therefore, I will be considering the artistic/holistic paradigm (Fish 1998) in the light of my experience as a researcher who tested it out in two areas.

Firstly, I have used the proposed methodology to explore clinical practice. This follows the format outlined by Fish and Coles (1998 p. 11-12), who gave examples of this in practice, and Fish (1998), who developed the theory from the practice.

Secondly, I have extended the use of the proposed methodology to research practice itself. In this I am not only reflecting and appraising an episode of research practice I undertook into my clinical practice, but I am also incorporating the principles of this methodology into the actual research process. This is a subtle but important distinction. The research process became the research focus, rather than a means to researching something else.

Usually when research is undertaken the methodology is chosen in the initial stages and this guides the process. The results, or themes, arising within qualitative research emerge as the research progresses, but the basic tenets of the methodology do not. In this study, however, although the themes were evolving, so was the methodology. This methodology and the way in which it emerged are the results. My research practice dictated the methodology, not the other way round. This involved artistry and it is that artistry inherent in research practice that I am exploring. Research practice is one facet of professional practice that entails artistry, which from my experience we need to acknowledge and explore.

This study is about my research practice. The same dilemmas and controversies about theory and practice that apply to everyday clinical practice are equally pertinent to research. Ryle states:

> Efficient practice precedes the theory of it; methodologies presuppose the application of the methods, of the critical investigation of which they are the products.
> (Ryle 1949 p.31)

The theory of the research methodology could not be articulated before the research methodology was evolved and critically appraised. I am theorising from practice, not applying theory to practice. Likewise, this is what I have done in the exploration of the episode of clinical practice. In both these instances, I am a practitioner first and foremost exploring my own practice. However, I did bring theories to this research when I started it. These were personal and formal theories, and were discussed in chapter five because they influenced my research. Indeed, my statement above about being a practitioner first is a key personal theory.

If the basis of this study was solely the exploration of my clinical practice using the artistic/holistic paradigm, then the discussion of the methodology would have been rightly placed at the beginning of the thesis. The portrait of practice and the critical commentary would then have followed as the results of that inquiry. In this instance, the exploration of my clinical practice was instrumental to the exploration of my research practice, which is the fundamental inquiry.

Although the rationale for the methodology only became clear towards the end of the study, I have presented the reasoning for its use at the beginning to enable the reader to understand the chronological sequence of the practice, but not necessarily experience the tortuous path and frustrations inherent in it. I am now focusing on appraising the methodology itself, through my reflections on its practical outworking in this study.

THE PORTRAIT OF PRACTICE

The portrait of practice is central to this work. Its creation follows the traditions of artists and is an artistic endeavour. This is not the same as producing a 'scientific' account within either the positivist or social science paradigms. Nevertheless, this does not negate the truth revealed in this artistic account, albeit different from those 'scientific' ones. A pertinent comment written about a GP with an interest in art is:

> Sometimes a good painting may persuade the subject of the existence of genuine qualities that previously they did not see in themselves. (Radcliffe 2003, p.15)

In this instance he was referring to portrait painting, which he undertakes alongside his medical career. His comment, however, summarises the intention of the portrait of practice to enable practitioners to see their practice anew. This was my personal experience, as I created the portrait I came to see aspects of my practice I had not recognised before. One important area for me was my role as a healer.

There is a need for practitioners to recognise the usefulness of adopting the methods of the arts to explore practice. A portrait of their own or their colleagues' practice is one example. McNiff writes:

> Art-based research grows from a trust in the intelligence of the creative process and a desire for relationships with the images that emerge from it.
> (McNiff 1998, p.37)

His comment emphasises the creative nature of this enterprise; its artistic foundations. There is a real need for us as researcher/practitioners to foster and trust our artistic abilities both in our clinical practice and research practice. The two will complement each other. This is something I have come to appreciate through this study. One problem that researcher/practitioners will experience is allowing themselves to embrace this alternative perspective. Practitioners have become wary of anything labelled 'artistic'. There is a strong message conveyed, which I have picked up as a clinician, through evidence-based medicine that the only worthwhile 'truth' is the version arising from the positivist paradigm view.

Certainly, as I endeavoured to create the portraits of practice, the process initially felt alien to me, and at times threatening. I referred to this in chapter one as a sense of walking through a fog - not a pleasant experience. Looking back and reflecting on the whole process, there was a need to experience this and I think this process is an integral part of artistic research. McNiff describes this as he observed it with one of his students. I include the quotation here because he captures an important aspect well:

> Artistic inquiry rarely follows a linear and certain path. Her research can be likened to a shamanic initiation in which she travelled into the vicissitudes of the creative process in order to know and understand it....If we become personally involved in art-based research, we experience how the deeper transformations of creation often involve a shamanic or Dionysian dismembering of the way we view ourselves and our existence.

(McNiff 1998, p.76)

There were times in the process when feeling dismembered was an apt description. It was uncomfortable. Many of my deeply ingrained assumptions and beliefs about scientific research and professional practice were radically challenged and changed. (Many of these had their foundations laid within primary school education, when the message that only hard 'objective' scientific fact has true value.) At the same time, this process had to be experienced for this work to be valid, and is one of the reasons why it is indeed educational research, and so has an important place within continuing professional development.

There are several stages in creating an artistic portrait, and these are mirrored for the practitioner who is creating a portrait of practice. At the outset I would emphasise that what follows should be seen as a possible framework for other practitioners wishing to embark on similar work, not a prescriptive method. The fact that this is a creative and artistic undertaking means this type of work cannot be copied, but the purpose is to inspire others to undertake similar creative enterprises. The guidelines, elucidated by Fish (1998), are essential and need to be understood but they do not constitute a manual or procedure to be adhered to. Indeed, if that occurred, this would be reverting to a technical-rational view of practice rather than embracing the professional artistry view. Fish illustrates this well in her references throughout to the working practices of artists. She points out that they work within traditions, which provide the guidelines, but each piece of work they produce is unique to them. She aptly contrasts the work of an artist within a tradition, which is the model of the researcher/practitioner in this paradigm, to the painter who 'paints by numbers' (Fish 1998 p.218) and follows a set of rules.

I had to recognise there was no set of rules to follow only guidelines, which gave me a framework within which to work. That was frightening and I struggled with it. Initially I spent a lot of time looking for the 'right' answer. Gradually I realised there was no absolute right or wrong in the sense to which I was accustomed. I had to trust my own judgements and start to discover my own creative abilities. I have never considered myself to be artistic so this was a very novel experience for me. In fact I came to realise that struggling to recognise these creative abilities within me as I

worked on the portrait opened my eyes to see these processes in operation within my clinical practice. That of course is the first step towards valuing them appropriately.

Recognising the Subject Matter

I have already outlined in chapter five the journey I undertook in realising the focus of this work for the portrait. At the outset, whether with a portrait of practice or another artistic undertaking, there must be a sense of vision. By that I do not mean a visualisation of the finished work, or even a clear sense of what it might look like. Rather, I would describe this vision as a sensing and desiring to pursue something worthwhile, something of value and therefore of beauty, which is what I experienced in the initial stages of the study.

Readers may find it quite strange to contemplate the discussion of beauty within medicine, largely regarded as a scientific endeavour and associated with technical interventions. However, if my arguments in favour of professional artistry have been successful, seeing beauty in professional practice, which is a work of art, will be understandable, in just the same way beauty is recognised in art. By the same token, professional practice, which is in some way internally inconsistent or flawed, lacks that 'beauty'. The beauty, or artistic merit, of a work is illustrated by the art critic's appreciation of it. This aspect will be further elaborated in the chapter on critical appreciation.

I was seeking, though not yet fully comprehending, the artistry within my own and colleagues' professional practice. I knew there was a way that individuals' needs were met in a timely and professional manner when they presented to an EMH service. As I argued in chapter five, this was not embodied through a technical intervention or social interaction but rather an episode of professional practice. Of course, this encompasses technical interventions and social interactions, but also includes more complex and intricate layers interwoven in a unique way for that individual. There are so many things operating at once that often they cannot be teased out separately but can only be appreciated in a holistic view of the practice. Fish explains this well and for this reason I include this lengthy quote:

Thus, artist practitioners whose practice is of a high quality match the demands of the moral ends they are seeking to achieve to some highly appropriate and well-executed professional skills and capacities and positive personal qualities. And such a match causes them to operate in a style which cannot fully be done justice to by breaking down the component parts of their practice, because there will always be some irreducible element of mystery. It can therefore only be referred to as the ability to act with professional artistry. It consists of a *whole process* – some aspects of which are invisible to the eye – in which many things are happening at the same time or in which one set of actions is simultaneously achieving many different ends, but which will never yield fully to analysis.
(Fish 1998, p.199-200)

In this passage she illustrates the operation of professional artistry, the ineffable elements inherent in this and the need for a holistic view of practice.

As a practitioner/researcher, I was responding to the artistry of professional practice within the EMH team. This was something worthwhile that I caught sight of when I began this study and was the vision that kept me going when I felt I was walking through the fog as described in chapter one. I have no doubt that the appreciation of this artistry was an important reason for my choice to work with this team, both for this study and later to return to as a consultant. This sense of 'something worthwhile' I experienced was the factor that kept me going and inspired me to continue to try and understand what it was that I was sensing but couldn't explain. Over time I came to the realisation that this something was artistry and I feel this has enriched my own practice and facilitated my appreciation of other practitioners' practice with whom I work.

Fish outlines five key points to determine whether a piece of practice merits recognition as artistry rather than craft, and therefore whether it is a suitable subject for a portrait of practice. I am of course considering this at the end of my work as I reflect on the research process rather than at the beginning when I was selecting the subject matter for the portrait. If I undertake a similar piece of inquiry then this

would now come at the outset because of the insights I have gained during this journey. I would also re-emphasise that the distinguishing characteristics of art are originality and uniqueness.

Firstly, the practice must meet the profession's moral ends. In the case of Elsie, the aims were to restore her to a level of functioning and well being acceptable to her. This was a moot point and something I emphasised in the portrait as being her perception of it, not ours.

Secondly, the practice must be valuable as a whole. Certainly in Elsie's case the whole of the practice as it came together was central to her healing. There was not one intervention that could be argued was the key element and important aspects could not be portrayed in isolation of the whole.

Thirdly, the artistry is not dependent on the level of performance displayed. The artistry is inherent in the practice not on its surface qualities that might be visible to an onlooker. This is the reason it is so important to get beneath the visible surface to fully appreciate the value or otherwise of a piece of practice. This is why when I first started to explore this episode of practice I wasn't getting sufficiently below the surface to fully appreciate its value and I was dissatisfied with this.

Fourthly, the piece of practice must be worthwhile in its own right. Certainly Elsie was referred at a time of need by her GP and benefited greatly from the ensuing interaction.

Fifthly, the practice cannot simply be a routine that is followed. There must be evidence of imagination and improvisation and of adaptation as the episode proceeds; in other words, the end cannot be fully comprehended at the outset. This was certainly evident with Elsie. Initially she presented as an elderly lady with an agitated depression but within days of her first assessment, the complexities and conundrums of her case were evident to all the practitioners. This resulted in improvisation and creativity in seeking to comprehend these fully. Imagination was employed by the practitioners and myself in attempting to understand all of this in its entirety, often employing visual imagery. I had automatically created a picture to help me

understand Elsie's situation during the first interview with her, in the same way I frequently do with many of my patients. I did not realise the significant part this played within my practice until I created the portrait. Initially I found it very strange to include this imagery within the portrait and almost viewed it as an interesting aside.

I was reassured to realise that the subject matter I had chosen for the portrait did fulfil the criteria outlined by Fish, even though I was not aware of them when selecting this episode of practice. This also confirmed for me that I was recognising artistic practice even though I didn't realise this at the time.

Before leaving this section about choosing the subject material for a portrait, I would draw the readers' attention again to the circles of reflection I spoke of in chapter one. The outer circle of reflection focuses on my research practice and is the portrait of practice within which Elsie's portrait is embedded. This also fulfils the five criteria considered above.

The research practice does meet the moral ends of the profession and is worthwhile undertaking in its own right. It seeks to find a way of exploring professional practice to further professional development and ultimately affect the quality of care patients receive. This is irrespective of any collateral benefit such as the award of a PhD. To understand this practice, it certainly needs to be viewed as a whole, and focusing on one small part of it, for instance the original fieldwork, would convey nothing of its true purpose. Undoubtedly, improvisation and creativity have been features as this work progressed. The research practice has mirrored professional practice in being an artistic endeavour and is therefore appropriate as the subject matter for a portrait of professional practice.

Characteristics of the Portrait of Practice

I will now consider some of the characteristics of a portrait of practice that provide a basis for understanding its production and its appreciation when reading it.

Case Study

A portrait of practice is a specialised form of a case study. It is a case of professional practice and is a study or in-depth exploration of this, employing artistic means to do so. Yin (1993) talks of the case study as a tool of research and emphasises its usefulness 'when the phenomenon under study is not readily distinguishable from its context' (p.3). Professional practice is bound to the context within which it takes place and, as stated in chapter four, cannot be seen separately from its context. Golby also argues this point and draws this summary from a review of three quite different examples of case studies:

> All engage the researcher in enquiries they cared about. All are concrete and practical enquiries in real life contexts with important practical results. They are all contained in boundaries of space and time, having a beginning, a middle and an end. They draw upon a great variety of methods, in more or less opportunistic ways.
> (Golby 1994, p.8)

An important element is that the researchers cared about the issues they were exploring. I do not think it would be possible to create a portrait of practice unless you cared about your subject and were involved in a real sense with seeking to portray it. Likewise, artists have to be engaged with their work; something about their subject captures their imagination and they then seek to portray that 'truth'. Right from the start of this work I cared about this project and owned it in a very personal sense. I wasn't satisfied until I felt that I had done justice to the 'truth' I was seeking to portray. Early on I recognised the case study of the episode of clinical practice. However, it wasn't until I was nearing the end, and discussing the way in which to present this work in the thesis with my supervisors, that I came to recognise the case study of my research practice. Seeking out meaningful research for the practising clinician had captured my imagination.

The other pertinent issue Golby draws attention to is that a case study does not determine the methods used but rather provides a framework within which they can be used appropriately. This is relevant to the artistic/holistic paradigm in which Fish (1998) emphasises the appropriateness of an inclusive attitude to different

methodologies. The choice is dictated by the focus of the inquiry, as opposed to the focus of the inquiry being dictated by the methodology adopted. I emphasised this point in chapter one and discussed embracing the artistic form of truth within this paradigm while remaining inclusive of the scientific view of truth exemplified in other paradigms. Reflecting now on this work this flexibility within a case study framework is central to the artistic/holistic paradigm. I had to continually adapt my approach to the needs of the work rather than the work to the needs of the approach. I would argue that this is why the portrait and its appreciation are truly practice-based.

Another important consideration of a case study is its overall character. By this I mean whether the case study is predominantly descriptive, reflective/interpretative, or deliberative. Fish and Coles (1998 pp. 67-69) discuss these and offer examples of reflective and deliberative characters through the work of their contributors.

A descriptive case study seeks to offer an observational account. Even within this there will be some interpretation by the writer, for example what to include and how to present the material. Often, however, this aspect of the writing is not acknowledged and rarely explicitly explored.

A reflective/interpretative case study offers reflections or interpretations from several perspectives. These can be from the people involved, the observations of the writer, and the context of the case as understood in its wider applications, including the traditions of the profession involved. This then moves from a primary aim of description to offering an understanding of the case in its context. An example of this is Hillier (1998) who examined a personally challenging episode of professional practice. My experience is that this is the form that I and my colleagues usually engage within when discussing cases together, often on an informal basis.

In deliberative case studies, as well as description and reflection, there is a deliberation on the issues emerging from the writing of the study. These are often the contestable issues endemic to professional practice, and may not be immediately obvious in the initial reflections on the case in question. The process of writing can draw these issues into focus and, if the writer is receptive to their revelation, can lead to further investigation. The depth of the exploration goes beyond the predominantly

reflective case study. A good example is Chapman (1998) who, from reflections on her personal dilemma in assessing students, turns to consider the contestable issues inherent in assessments generally.

The case studies presented here, both of clinical practice and research practice, are deliberative in character. Both are descriptive and offer reflections of the processes involved. Equally, they both address the issues that emerge during the creation of the case studies and are investigated further through the critical appreciations offered. Within the clinical case study, the issue of professional practice emerged for me as a key factor and therefore I investigated this in depth in chapter four. As the study of my research practice evolved, the pertinent topic to surface was the purpose and function of research for practitioners. This resulted in my exploration of the newly proposed artistic/holistic paradigm.

The case studies in this type of work are a research activity and not a framework for the transmission of information in an agreed format, which is recognised as a clinical case study or presented within clinical practice. These are accepted means to facilitate communication between clinicians, rather than an exploratory endeavour undertaken within research practice.

To begin with I was trying to write a descriptive type of case study. I was concerned that I captured all of the information accurately and was concerned not to include too much interpretation. This was after all what I was used to in my everyday practice. Gradually as I redrafted the portrait (the sketching process) I became more confident to include these interpretations. At this point I think I had moved into a reflective/interpretative type case study and because, as I mentioned earlier, this does occur within everyday practice didn't feel too difficult. The real challenge I experienced was moving on to a deliberative type case study when I needed to bring into my awareness the contestable issues within the episode of practice that are endemic to professional practice. This isn't something in my experience that readily occurs in any setting within everyday practice. I certainly found this process was facilitated through the creation of the portrait but I also had to actively seek out these issues through time spent in reflection. It would have been easy to have remained at the level of a reflective/interpretative case study.

Autobiographical/Biographical Work

The portraits offered in this work are a combination of autobiographical and biographical work. The research practice is autobiographical because it details the journey I undertook in research practice, and is narrated by me. The portrait of clinical practice is a combination because I undertook this personal journey with other practitioners, who became fellow researchers of their practice with me. An important observation by Bolton (2001, p.29) is 'I am a story I tell and retell every day'. Similarly, Bochner (1997) emphasises that we are the stories we live. I personally think we underestimate the power of story telling in our individual and corporate lives.

Autobiographical/biographical work is recognised in its own right as an art form and this is discussed by Fish and Coles (1998 pp. 214-221) as an appropriate form of research in this type of work. The practitioner is central to the professional enterprise. Their own history and personal attributes are key factors in their functioning as practitioners, and shape their style and view of situations. As I mentioned in chapter five, the fact that my husband is an artist has significantly contributed to my understanding of artistry. The practitioners' professional education and experiences will have affected their approach, but no two people develop in the same way. There will be similarities and significant variations. To understand an episode of practice there is a need to access the thinking and reasoning of the practitioner. This needs to include all the influences, some of which may be deeply embedded in the person. All elements of the iceberg (Fish and Coles 1998 pp. 305-306) need to be accessible for review.

The use of autobiography and/or biography allows this to occur. This form fosters the description of the actual events combined with access to the usually private thoughts and reflections of the practitioner. As the portrait took form I began to realise how important accessing my thoughts and reflections were in order to understand my professional judgements. These judgements form the basis for my practice and I came to appreciate that they would have a key role in determining the artistry within

that practice. Furthermore, relating or writing the account allows a critical appraisal to begin; a self-scrutiny. Fish and Coles describe this:

> Rather, the autobiographical process – as known about in its literary genre including its struggles with objectivity, form shape, balance, style, image, reflection and introspection – *becomes* the research and enables the researcher to uncover a range of levels of analysis and interpretation of his or her practice and to attend with some justice to the complexity of personal-professional interrelationships, decisions and judgements.
> (Fish and Coles 1998, p.220, italics in original)

Importantly, the account, or autobiography, becomes the research and is the subject of the portrait of practice. Out of this come related investigations, and the practice has primacy. Once the practice began to make its impact on me through the creation of this account, the issues I spoke of in the preceding section began to emerge. Therefore from my experience this form does foster the deliberative inquiry, which truly grapples with the issues endemic in professional practice.

My own experience confirms this for me in this work. From the perspective of my research practice, writing an autobiographical account enabled me to discover why I thought about research in a particular way and why I felt dissatisfied with it. As I began to examine some of my underlying beliefs and assumptions about this, I was able to take a step back and survey the wider context and traditions within which I was embedded. This then fostered a critical appraisal of all these aspects, which gave me the necessary distance and overview to choose to develop my own research practice. As I produced the account and my reflections on it, the account has crystallised for me the wider issues concerning research practice and nurtured a critical appreciation of those issues, and in particular the proposed artistic/holistic paradigm. The process emanated from my own journey, which I have researched through an autobiographical account, rather than from the process being applied to my journey.

The account of the clinical practice with Elsie was a combination of both autobiographical and biographical elements. I travelled with Elsie and formed my own professional judgements, and I observed the team working with Elsie and discussed their professional judgements with them. Using this form allowed the inner thoughts of the practitioners to be heard and also fostered further reflections on these processes. Important issues relating to professional practice in a wider arena were clarified, and were then investigated in more depth. I would therefore agree with Fish and Coles (1998 pp. 214-220) and would argue, as they do, that this form is appropriate to this type of inquiry.

The Artist's Viewpoint

Within the portrait of practice, it is important to understand the artist's viewpoint. This is one of the key features which distinguishes the portrait both in its creation and its final form from other accounts or case studies. The viewpoint a person has does of course affect the way a person approaches a project and their vision of it. I had to learn to view my practice through an alternative viewpoint and this occurred gradually, almost unknowingly to me initially. The main impetus to this development was discussions with my supervisors and other researchers, which challenged my accepted views of practice. I then came to appreciate the alternative viewpoint that I had acquired as I appraised the creation of the portrait of clinical practice.

In this type of inquiry, the researcher adopts the working practices of an artist to explore the artistry within practice. In doing this, the researcher moves beyond cultivating a discerning eye, whereby there is a recognition and appreciation of the artistry inherent in practice, to using the means within the arts to explore and convey this artistry. This is evident both in the creation of the portrait and in the critical appreciation, when the role of art critic is adopted. At the outset I was cultivating a discerning eye, I would argue I already had an awareness of artistry but I wasn't recognising it as such. Once this began to occur I then progressed to learn to use the artist's tools.

I had to learn to think and operate within the realm of artists and their traditions to create a portrait. I examine some of these practical aspects in more depth in the next

section. However, before I could start to use the artist's 'tools', I needed to see things from an artist's perspective rather than a scientist's perspective. From my own experience this will probably be the biggest hurdle for practitioners to overcome when they encounter this type of work for the first time.

I want to start by considering the 'truth' that the artist seeks. By now I think it is evident that I have moved away from the premise that the only 'truth' is the supposedly objective truth portrayed by the positivist paradigm. In the artistic paradigm, the truth sought is artistic truth. In the same manner that artists capture a vision of an aspect of life, which they then seek to convey to their audience through their artwork, the researcher captures a vision of professional artistry, and through their portrait or 'artwork' seeks to convey this to their audience. The vision or 'truth' the artists endeavour to impart can only be fully portrayed in their artwork. Parts of this work may be open to analysis but this will not include all of the work, and the analysis alone will not represent the vision. McNiff (1998 p.164) points out that 'artistic knowing is unique in its ability to express and display these multi-faceted qualities of experience'. The artistry of professional practice is multi-faceted and can only be truly seen by viewing the whole. This is the 'truth' that both the artist and the researcher seek. Fish (1998) aptly uses the term 'artist researcher'.

This relates back to my earlier discussion in chapter one of Eisner's (1998) distinction between representational and presentational symbols. Art uses forms to present the experience directly to its audience. As Fish (1998, p.213) reminds us, 'the artist is not a photographer and the novelist is not a scientist'. This is why a piece of art or a novel can impact on us and resonate within us, connecting to a deep level of our being. We can then attest to the fact that this work has indeed imparted a significant truth to us. All of us, I expect, can remember books or films that have done this, even though we may not be able to explain fully the reasons for their effect. This 'truth' is quite distinctive from the generalisable laws that science seeks to impart, but are nonetheless equally valuable. Perhaps in some instances they are more valuable because the issues this 'truth' relates to are more relevant to everyday practice. I believe the 'truths' imparted in the portrait of Elsie are of more use within everyday practice than those characterised through an evidence-based medicine approach, which would offer the label 'an agitated depression' and lead to a review

and appraisal of the literature on the treatment of this condition. In addition, these 'truths' from Elsie's portrait have a general relevance. Winter et al. portray this well:

> This 'symbolic' quality which artistic structure gives to particular events is both a sort of general truth and at the same time a sort of openness and undecidability.
> (Winter et al. 1999, p.203)

There is a connection between the specific and other similar but different events. In the same way in relation to case studies, Golby (1994) stresses the need to use particular cases rather than unique ones so that the issues arising from the study have a wider application than just the case in question. This artistic 'truth' does not yield concrete laws and still leaves more to be explored. This again presents researcher/practitioners and their audiences with the inherent uncertainties in all forms of practice – clinical and research. This was a specific issue in the critical appreciation of Elsie's portrait, but as I now argue, it has wider implications within professional practice and everyday life.

Furthermore, the artist endeavours to enable the audience to see something that was there but which was either not seen, or was only partially seen. Fish talks of artists opening the eyes of their audience:

> By enabling this audience *to see* and to sense the world more sharply and be aware of the gains involved, artists increase that audience's appetite for such sensory experiences, both in the world and through art, and they enable that audience to experience the fuller range of their own sensory powers.
> (Fish 1998, p.217, italics in original)

This 'seeing' fosters a sensory experience that enables the audience to see or experience for themselves in other situations. The goal for the artistic/holistic paradigm is to cultivate professional artistry. Opening the eyes and giving an experience of professional artistry to both the researchers and their audience is the means to achieve this goal. This then promotes the recognition of artistry in other

professional situations, which prior to this encounter they would have either missed or only partially appreciated. Hence, the potential to develop their own artistry is enhanced along with continuous development of their practice.

I have experienced the artistry within my practice through this work and I have sought to give you, the reader, an experience of it through my writing. I am aware that early on in this work I began to recognise artistry in many of the professional situations I encounter and that awareness has opened the possibility for me to develop it further. One area I have become aware of this is in, is in the supervision of trainees and being 'in tune' with their learning styles. I believe that has developed my practice as an educational supervisor.

Fish (2003[1]) makes the point that, 'ironically, the 'honest truth' is often conveyed by the artist by means of artifice (through techniques of distortion or emphasis which are larger than life or different from reality)'. For example, Lucien Freud cleverly uses brush strokes to bring out a reality within his portrait work. The portraits he creates are not photographic representations but convey a quality or essence of their subject. They certainly stimulate a response, not always favourable, from the audience. Within the portrait of practice, figurative language has a particular role in this respect. In the story of Elsie, a picture or artifice was offered to convey an understanding of her situation. This, I believe, conveyed far more and to a greater depth of understanding than I could have done with pages of factual description.

Each artist develops his or her unique style. Their work is enmeshed with them as a person; the two cannot be separated. To try and disentangle the two would destroy the art because the creative process emanates from the person of the artist. Within professional practice, as I have argued earlier, the practitioner cannot be separated from their practice. This is not only true for clinical practice but also in research practice and in particular, this type of artistic inquiry. All artists have to find their own style. Within this work Fish (1998) talks of them finding their voice. I think this is appropriate for professionals who have been indoctrinated not to trust their own voice and to sanitize all communications, especially research orientated work, of any

[1] Personal communication: Fish, 2003.

personality. The practitioner and their subjectivity are seen as invalid and to be avoided at all costs. Unfortunately, the cost has been the loss of the appreciation of professional practice as I detailed in chapter four.

I had to find my 'voice' and become confident to use it. This continued to develop right up to the final version of the thesis and I have no doubt will continue to do so. My voice will have similarities with other practitioners, especially other Old Age Psychiatrists, but it will remain unique to me. In that sense it is not generalisable although it does have relevance for other colleagues. This is why another practitioner's portrait of the same episode of practice would not be identical to mine and quite rightly so, because you would be hearing their voices not mine.

Fish expands on the style, or voice, within literature and underlines that it is a 'major means of conveying vision' (p.231). Earlier she states:

> Successful writing depends on creating a voice which is appropriate to the writer, the subject and the intentions of the work.
> (Fish 1998, p.230)

In setting the scene to this work in chapter one, I discussed both the presentation and style of this work, to prepare the reader for a different format from the traditional one expected in a dissertation. In this work I am recounting my own journey both in relation to the clinical practice and the research practice. Often I adopt a conversational style, which reveals a lot about my personality. I am most at ease within a one-to-one exchange and indeed, this is where most of my professional work as a psychiatrist is located. Typically within my everyday practice I hold conversations with myself and think in pictures; one of the intentions of this work is to give the reader access to this reasoning. Therefore, to adopt a formal, distant voice would be false. At the same time, I have kept in mind that this work is for a dissertation and that there is a convention within which I must work. I had to learn to move away from the formalised voice expected within medicine to allow my own voice to emerge. Once I had the courage to experiment and develop my voice, I then had to learn to use it appropriately. For me that meant working on my writing skills,

which were never well developed during my education. Equally, this was an important part of the research process.

Fortunately for me, and perhaps other practitioners, Fish (1998 p.214, italics in original) stresses 'the success of such work *as art* is not of significance'. The important aspect is the success in revealing and promoting professional artistry. I have nevertheless had to strive to achieve a level of written style that could do justice to my subject.

This reorientation to an artist's viewpoint of professional practice was essential and was the first step I had to take when I commenced on this journey. It promoted a tangible concept of the artistry inherent in my practice, both clinical and research. The term 'tangible' is apt. Prior to this study I would have stated that medicine was both a science and an art. However, my concept and ability to convey it to others, or to myself, would have been limited. Professional artistry for me was a nebulous term. Adopting the viewpoint and stance of the artist, as suggested by Fish (1998), enabled me to ground this concept in the reality of my own experience as a practitioner. This was an important and worthwhile development for me, the practitioner, even if the practical outworking, whereby the artist's techniques are adopted, were not followed.

I will now consider and appraise some of the practical issues involved in the creation of this portrait. This is the point at which Fish's work moves beyond the earlier work of Eisner (1998), who argued for an appreciation of the artistry in educational practice but did not advocate working in the same manner as an artist to explore this. The question I address is whether working in the same manner as an artist is indeed valuable and worthwhile for the practitioner.

The Creation of the Portrait

Although I discuss separately the different stages I passed through in the preparation of this portrait, I would emphasise that all these stages overlapped and interacted. The division into stages is to bring clarity to the discussion.

Selecting the Subject

This task was not clear-cut and only came into focus as I began to produce draft sketches. The focus had to develop as my own understanding of the research practice began to clarify. Up to this point I had been working on six case studies and had carried out a total of 55 interviews and three focus groups. Therefore, in the more recognised qualitative mode of research, I had a wealth of data from which to work. In comparison with work in the positivist paradigm, this would be considered a small amount of data and would certainly be statistically irrelevant. However, it was too much and not the relevant type of data for the artistic/holistic paradigm.

In the artistic/holistic paradigm the work is small scale. Fish states:

> …empirical work in the artistic/holistic paradigm is small scale. The intention here is not to amass large amounts of data but to collect only that information which enables the practitioner researcher to work in detail on understanding a selected piece of practice.
> (Fish 1998, p.192)

This is a fundamental difference from other types of research. A danger is that this type of research will be judged on the expectation that similar amounts and types of data should be amassed as in other types of research. Only the empirical data, which is useful for contributing to the understanding of practice, is gathered. Data, in this sense, is not sought for the sake of it or to increase the validity or trustworthiness of the results. The rigour of this research is located elsewhere, in the writing, a point I emphasised at the outset.

The nature of the data in this paradigm is also different. Indeed, I am not sure the use of the term 'data' is the most appropriate or helpful. An artist collects background material to inform the work. In this context, of working in the artistic/holistic paradigm, I would suggest the term 'background material' is similarly adopted. The background material includes the interviews I conducted, and these inform the portrait. The portrait itself and the process of creating it is, however, the data. Fish outlines this important point:

> Uncovering new knowledge and developing new understandings and new techniques are, in the world of the arts, *part* of the creative process, and will mostly occur not as a result of collecting yet more material, but *during* the production of both drafts and the final version. The portrayal of practice is not an exact factual matter, but rather is about catching the spirit.
>
> (Fish 1998, p.213, italics in original)

'Capturing the spirit' is vital for the appreciation of this work. Therefore, as the researcher entering this new paradigm it did require a paradigm shift in my thinking. The first shift had to occur in my selection and understanding of my subject matter for the portrait, which then formed my background material for this investigation. I realised I needed to choose one of the case studies to develop into a portrait. Elsie's was my choice because this episode of practice captured the 'something' about practice that went well. I recognised in this episode some of the aspects of practice I was struggling to articulate but at this stage could not even explain to myself. The other cases portrayed many of these qualities as well but I felt instinctively that Elsie's case demonstrated them more fully.

However, having selected Elsie's case as the subject, I still did not fully comprehend the subject matter of the portrait. For a long time I was still seeing it as a case about Elsie and her needs. Indeed, when I was working within the interpretive paradigm that was correct as it focuses on Elsie, the patient, and seeks to understand her needs primarily from her perspective. In this instance, she is the expert and the focus, and therefore, she is the subject of the case study. The focus and the aims within the artistic/holistic paradigm are subtly different. The purpose is to explore professional practice and the professional judgements being exercised in the care of Elsie. Understanding and comprehending Elsie's needs from her perspective is paramount to this, but is only one aspect. Just as important is a grasp of the processes occurring within the judgements made by the practitioners involved, which then impact on the interaction with Elsie and the healing process.

A full realisation of this occurred for me in the revision of my fourth draft sketch. At this point, one of my supervisors asked me to clarify the subject of my case study. As I began to articulate it, I realised the subject was the episode of professional practice not Elsie's story anymore. Until then I had continued to write the account as if it was still Elsie's story. I was then able to focus more clearly on the appropriate subject matter for the final portrait, which was my professional practice and the judgements this entailed. This emphasises how all the processes I am currently discussing overlap and do not occur in a linear way.

The Sketching Process

If you talk to an artist about the creation of a finished work or observe them at work, as I have been fortunate to be able to do with my husband, it quickly becomes apparent that a lot of experimental work occurs prior to having a clear idea of the work's final form and certainly before commencing on the final piece. Even at this point the experimentation is not complete. The final piece is worked and reworked and it is only at the end that the artist knows exactly what form the work will take.

In the artistic/holistic paradigm, the research practitioner adopts the methods of the artist. Therefore the process outlined above is mirrored within this type of inquiry. As a consequence, uncertainty has to be accepted and tolerated, a point I keep coming back to but which is essential if the creative process is to be nurtured. The creative process is fundamental to this type of research. I found that until I started to trust that creative process I couldn't even begin to understand this type of inquiry. For me this came about when I made myself sit down and start writing the portrait i.e. the draft sketches. As I wrote these and revised them I experienced this creative process and this personal experience was much more powerful than merely reading about it. Yet again practice has primacy of place.

Work on the portrait of practice begins with the production of draft sketches, or draft pen portraits. This enables experimentation and begins to allow the artistry within the practice itself to emerge. During this process, I began to recognise that artistry, and I was seeking an effective means to portray that artistry. Producing and working on the draft sketches was an important part of the process. This stage could not be rushed

and at times required me to stand back and allow the drafts to impact me, something Fish (1998) talks about and confirmed by my experience. Reflecting and deliberating enables the full implications of the piece of practice to begin to emerge. The impulse to analyse them into component parts had to be resisted. I had to sit, as it were, and look at the whole. It was during these times, interestingly that I felt I began to comprehend the artistry within the piece of practice. This is different from the normal research practices practitioners have become accustomed to.

As I started to work on the draft sketches, I initially had to cast aside much of the previous work I had done on Elsie's case study, for instance the thematic analysis of her needs. In these initial stages it distracted me from being able to view the whole episode of practice. Later, when I had begun to appreciate and capture that 'wholeness', the earlier work was useful. (Examples of this earlier work are included in appendix 4.)

As I stated earlier, and am repeating because of its importance, the view of professional practice gained by the use of this methodology is just one view. There are many views, or perspectives, that could be employed and each would have a valuable, although different, aspect to contribute to the understanding of practice. I am not therefore negating the earlier work that I carried out in the interpretative paradigm. As I pointed out in chapter five, this could have been presented in its own right for this thesis. But, that approach did not address the aspect of professional practice I specifically sought to explore, namely artistry within practice.

To facilitate this view of the whole episode of practice, I found myself reading the transcribed interviews repeatedly, and listening to the audiotapes. The audiotapes were particularly useful because I found that listening to them enabled inferences to be picked up which cannot be represented in the transcribed version. In addition, I was now listening in a different way. Before I was seeking out categories for the thematic analysis, even as I transcribed them. Now I was allowing the episode of practice to impact, or speak to me, in its entirety. I approached the practice this time with no predetermined expectations. As I did this, there grew within me a sense of the 'spirit' or essence of the practice. The vague feelings I had that there was something worthwhile and of 'beauty' within the practice began to crystallise and

take form. At this stage that form was shadowy, but nonetheless real. It was the form I would work on to see clearly and then find a means of conveying it within my writing.

In conjunction with this ongoing process, I was spending time reflecting and deliberating on the practice and the emerging picture of it. This reflection was similar to the reflective process I describe occurring within the clinical practice itself, as seen in chapter two. As in that instance, I would quite often find myself mulling things over when I was engaged in something quite unrelated and those were often the times when the most pertinent insights would develop.

Issues related specifically to Elsie's care and more general issues about practice started to come into focus. These were addressed in the portrait and were also developed in the critical appreciation; as I stressed earlier, this is not a linear process. One example was the understanding of the healing process. Certainly for Elsie this was not about the right medication at the right dose. If anything her story contradicted all the evidence-based medicine. This prompted further reflections, specifically on the process of healing for Elsie but also led to a wider examination of this within medicine during the critical appreciation.

The iceberg of practice (Fish and Coles 1998 pp. 305-306) began to be revealed. Theories in use became clear and this illuminated many deeply-held values and beliefs that were underpinning my, and the colleagues I worked with, practice. Yet within the busyness of everyday practice, they are not acknowledged, and within the current culture of evidence-based medicine are unlikely to be valued. This is seen in regard to the inherent uncertainty within professional practice, discussed in chapter three. Throughout the interaction with Elsie, all the practitioners, including me, knew that our understanding of all the aspects of the case were tentative. Even though at the end the practitioners were confident their understanding of Elsie was enhanced and a 'better fit' to her needs, we all knew it was incomplete and there would always be unanswered questions. Sometimes, as I underlined both within the portrait and the critical appreciation, it can be in the patient's best interests for the practitioner to accept some uncertainties and to live with them.

Deliberating both with myself and with critical friends was essential to this work. In this respect my supervisors were in a real sense those critical friends. This also included talking things through informally with other colleagues, and with family and friends. The importance of all those discussions should be valued. Each brought different viewpoints and extended my own thoughts and reflections. Another aspect that promoted this process was presenting this work in different arenas, for instance educational meetings. Not only was the feedback and discussion valuable, but preparing the work to present it helped in my deliberations.

Keeping a portfolio of the work, similar to an artist's, was invaluable. This is believed by Fish (1998) to be essential. I found it included the draft sketches and also thoughts I was developing that directly related to Elsie and to the wider issues. This portfolio contributed to all aspects of the final dissertation, even though parts of it will not be directly included. I would describe the portfolio as the laboratory within which I experimented (see appendix 5).

The Final Piece

The sketching and experimenting takes place until a point comes when, as the artist researcher, you are aware that it is time to begin the final portrait. However, like the artist, this is not accomplished in one step. The portrait is worked and reworked until you are satisfied with it. Equally, the researcher has to know when to stop, as perfection can never be achieved and going on too long can lead to marring of the work.

At this point, I was beginning to grasp the artistry within the episode of practice and now began to wrestle with the task of expressing it. There were many aspects I had to attend to simultaneously. The portrait would not be a case study in the sense that I was used to in medicine, but at the same time I had to consider my audience. There were two major factors in this consideration. Firstly, if the piece was too innovative in its presentation or form it could immediately alienate fellow practitioners, my primary audience. Secondly, as with any piece of writing, the needs of the audience to know relevant background information and details must be understood and met. I found it easy to assume that the audience would know certain details that were

obvious to me as a practitioner. This highlighted for me how easily the same situation arises in everyday clinical practice.

I was aware that I wanted to present the episode of practice in a chronological sequence, from the initial referral through to the end. This would give the audience the opportunity to experience the episode of practice as it unfolded and access the thinking and reasoning of the practitioners, including myself. To facilitate this access to the practitioner's thought processes, in particular mine, I used a sub heading 'reflections' at strategic points along the encounter. I felt this enabled and highlighted for the audience the change in presentation. The heading made it obvious that these were reflections not hard facts being presented. It meant that the audience was almost entering into my mind, the practitioner, and hearing my conversation. The audience became privy to my deliberative judgements regarding Elsie, which arose from my own interactions with her and with other members of the multidisciplinary team. This, after all, reflects what happens every day in clinical practice when I am assessing patients as a Psychiatrist.

This means also opened the opportunity for me to introduce figurative language to convey a holistic perspective of practice, which then included the ineffable parts of practice that cannot be analysed. Fish reminds us:

> It is less about prettifying visible matters already conveyed, than about expressing the ineffable which has not yet been captured. In all cases, it will only be successful if it emerges from the content rather than being imposed upon it.
> (Fish 1998, p.234)

Just because the artistic/holistic paradigm opens the possibility to use figurative language does not mean it should be used for the sake of it, or inappropriately. The purpose will usually be to convey something of the ineffable or a holistic perspective, and should arise naturally. In Elsie's portrait, the metaphors used arose naturally within the clinical practice and had already been formed within the practitioners' minds. For instance, the CPN spoke of the case being like a pebble dropped in the water with ever increasing circles. This conveyed much within the portrait but it was

already there in the clinical practice. Again, this highlights the widespread use of figurative language within everyday practice, but most of the time practitioners are reluctant to acknowledge its use or importance in informing their practice.

There were times when I had to stand back from the portrait to gain perspective. This could mean leaving it for a few days and returning to it afresh later. Other times I would return to the original interviews. There was a lot of reworking, for instance highlighting certain aspects or pulling other aspects away from the foreground. Developing my own natural voice, or style, required a lot of trial and error. Finally, however, the portrait was complete and the critical appreciation began to take shape. The issues that were addressed within it had already been emerging during this first production.

CHAPTER 7: METHODOLOGY AS AN EMERGING RESULT OF THIS RESEARCH – THE CRITICAL APPRECIATION

INTRODUCTION

This is the point at which I take the formal role of the art critic, unlike the artist who usually leaves this to another in the public domain. Artists do however continuously critique their own work, both in the production of it and after its completion. In fact, from my observation of my husband, they are usually the most demanding of all the critics. This critical appraisal however, usually remains a private affair, unlike that of the art critic. By this stage I had begun to develop a discerning eye, that is, to be able to recognise artistry within my practice, which prepared me to commence the appreciation. Fish points out:

> A critical commentary in the arts is the means of thinking about a particular piece of art *as a whole* by responding to it holistically, and by seeing it in a broader context. The same process applies to appreciating professional practice and its artistry. Here consideration of the broader context enables us to relate the portrait and its subject to the traditions of practice of that profession, to the life of the professional, and to a range of professional considerations and their associated literature.
> (Fish 1998, p.240)

Primarily the critical appreciation is responding to the portrait, and through it to the practice on which it was based. This is the point at which the discussion opens out to wider issues. It moves beyond the piece of practice alone. The piece of practice and the portrait, which arose from it, become signposts to these other broader issues that impinge on professional practice. This too, is a work of art. There are general principles to work within but no set rules. The aspects and the ways in which they arise in the appreciation are individual to me, the critic and the portrait I created. The vision I sought to convey within the portrait is further developed and deepened. I was

certainly surprised how similar producing a critical appreciation was to the portrait. This too I realised was a creative process.

Fish (1998) emphasises the diversity of the issues, which may be considered at this stage. There are issues related to the traditions of that profession, the life of the professional, as well as many other considerations around professional practice. In the critical appreciation, I present many of these. For example, the aspect of professional practice arose as a major theme, and the central factor in the provision of a needs-led service. As a consequence, a whole chapter was devoted to this subject. This certainly relates to the broader context and traditions of professional practice, but the signpost to it arose in the portrait. It is therefore appropriate to the appreciation, even though reading it there is little direct reference to Elsie's case.

Just as the artist has his or her own unique voice within the portrait I have come to realise this is true also for the critic. In this instance I was both artist and critic but that does not have to be the case. Someone else critiquing this portrait may well have emphasised completely different issues within the portrait and both would be equally valid provided the signpost to them was evident within the portrait.

The critical appreciation further draws out the hidden aspects of professional practice. I devote the first part of the appreciation to considering the theories in use that I perceived operating within the episode of practice. These were becoming visible to me in the portrait but are brought fully into focus within the appreciation. An important point here is that, although we label these aspects theories, they are not necessarily theories in the same sense as theories within the natural sciences. They are not universal laws or formulae to be applied in a technical manner. Rather, the theories in use often encompass the values and beliefs of the practitioner; in this case primarily mine but also incorporating shared values and beliefs within the EMH team. These are indeed theories because they underpin and guide practice, whether or not the practitioner is aware of them. Therefore, examining the theories in use is an important means to exploring the deepest yet possibly the most significant elements of the iceberg of practice.

THE CRITIC AND THEIR FUNCTION

In this type of work, the critic will often be the author of the portrait, but not always. Fish and Coles (1998) edit a book in which, a number of practitioners produced portraits, which Fish and Coles then critically appraised. Even when the author and critic is the same person, there is an adjustment between the two roles. The critic stands back from the portrait, and there is a detachment from the personal involvement in its creation to that of an observer. This is why both the original author and another person can be the critic.

I had to make this transition. I found finishing the portrait and then leaving it for several weeks before coming back to it completely fresh encouraged this. For me it was like looking at it through different eyes. I began to appreciate issues and nuances within it that I had previously overlooked because I was so closely involved in its creation. I had literally and metaphorically gained some distance from the portrait. I have noticed that my husband regards his paintings quite differently several weeks after he has completed them to how he does just after he finishes them.

The critic's function, like that of the artist, is to open the eyes of the audience. I had to enable my audience to see things that were already there but not noticed or only partially seen. My role and the means available to me are different from those when I was the artist. Whereas artists are creating the portrait as the vehicle for their vision, the critic is contemplating the portrait to draw out the vision within it, and to set this vision of artistry within the wider context of artistry in general. I was not creating the portrait now; therefore this allowed me to take a different perspective of it. Equally, critics may, through their appreciation, open the eyes of the artist to see things they had included unconsciously within the portrait. This was my experience especially when I returned to the whole picture at the end of chapter three. I was very surprised at some of my unconscious decisions about the content, form, style and shading within the portrait and what these choices revealed about my practice. Therefore, I strongly feel, even if a practitioner was only producing the portrait and appreciation for themselves, this would be an important educational exercise.

To function effectively as a critic, I had to first and foremostly be a connoisseur. This means to have the discerning eye that Fish talks of, the ability to recognise the artistry within practice. As I discussed in the previous chapter in the process of creating the portrait I had begun to recognise and appreciate the artistry within my practice, my discerning eye was being cultivated and preparing me for the transition to critic.

Eisner (1998) describes the attributes of connoisseurship in his discussion about the connoisseurship of wine. It is important to understand these attributes because they form the foundation from which the critic works. He talks of the need to have perceptivity; this is not just being able to taste the wine, but the ability to notice differences in this experience. There is also a requirement to appreciate more than just the taste, but also the colour and 'nose' of the wine. This could be seen as the local contextual aspects of practice. He sums up these attributes as dependent 'on high levels of qualitative intelligence in the domain in which it operates' (p.64). This could relate to developing a 'taste' as discussed by Fish (1998 p.241) in relation to the critical appreciation of practice. Eisner's final and important point, from his comparison to the appreciation of wine, is the necessity to appreciate the wine 'as a sample of a larger set of qualities' (p.64). In other words, the wine must be appreciated within the group to which it belongs. The wider context has to be appreciated and understood. This would also encompass the history of that particular wine. Likewise, any piece of practice must be understood in its wider context, including the history of the individual practitioner and the traditions of their profession.

Connoisseurship is, however, a private matter. I may be discerning regarding wine but never openly discuss it, and therefore unlikely to significantly impact on anyone else regarding this. In that sense, being a connoisseur does not mean I will be a critic. In contrast, the critic does share his connoisseurship, as Eisner explains:

> For connoisseurship to have a public presence, we must turn to criticism, for criticism provides connoisseurship with a public face…If connoisseurship can be regarded as the art of appreciation, criticism can be thought of as the art of disclosure.

(Eisner 1998, p.85-86)

Therefore, a critic must be a connoisseur. Their role is to reveal the appreciation of the value of the subject being considered. They are also seeking to go beyond just revealing the appreciation, to enabling their audience to appreciate for themselves and to become connoisseurs. Fish (1998, p. 243), quoting Eisner (1979 p.191), talks of the critic being a 'midwife to perception'. I have included this because the analogy conveys so much in just a few words. Fish also reminds us that critics should seek to render themselves redundant, as the audience discovers its own discerning eye. I was therefore at the stage where I was a connoisseur of artistic practice but I now needed to share this with others so that they too could come to a similar appreciation for themselves.

Critics must also keep in mind that the vision they are seeking to develop is within the portrait, and not something personal to them. I had to remember that my role had changed, I had already developed my vision of the episode of practice within the portrait. My role now was not one of interpretation but one of bringing into focus the portrait and all its inherent aspects. However, all critical appreciations are personal to the critic because their appreciation is affected by their own beliefs and values, and their own history, in the same way, this is true in professional practice. Therefore, these aspects must be made explicit to the audience, so that they can place the critical appreciation within the correct context. This relates back to my earlier realisation that as a critic you have to develop your own unique voice. The critic functions as a signpost to the portrait, which in turn is a signpost to professional practice.

THE CRITIC'S RESOURCES

I now turn to consider the resources that were available to me in the role of the critic to disclose the appreciation to my audience. The resources will be dictated by the purpose of the work. Within a critical appreciation there is the overall aim of making public the appreciation of the portrait. Within this there are many facets, and therefore different resources will be required. Fish points to this:

> A critical commentary can both open up an exploration of more detail in the portrait and its subject (reflect more deeply), or, equally, move away from the text and deliberate upon the issues it raises. Clearly, good critical commentaries do both.
> (Fish 1998, p.242)

There is both the focusing in on parts of the picture, and then drawing away to view the whole, like a camera lens, an analogy I used in the introduction to the critical appreciation in chapter three. In viewing parts in detail, there can also be a turning of the camera to focus on the issues that arise within the portrait. These are often those related to professional practice in general, and again those issues are considered close up and as a whole from farther back. However, at the conclusion when the camera moves back and focuses on the whole picture, all of these aspects are seen to have their origin in the vision developed within the portrait.

I was able to adopt various perspectives or viewpoints from which to view the portrait. All of these were valid but each brings something slightly different to the critical commentary. I chose initially to critique the portrait from the viewpoint of theories-in-use that were evident to me and later on in the appreciation I chose to consider the broad but contentious issue of professional practice. This variety of viewpoints brings a depth and richness to the appreciation. Equally, there will always be other perspectives that could be employed. For instance I could have chosen to critique the portrait from a psychotherapeutic perspective. A critical commentary will never be exhaustive.

An important element in the creation of a commentary is the actual person who is the critic. The importance of the critic should not be underestimated. Their personality, their experience and beliefs will contribute to the commentary, and these aspects need to be explicit because of this. My audience needs to appreciate I am a doctor and not a nurse, that I am a psychiatrist and not a psychotherapist all of this has influenced the perspectives I have on the portrait. This is in direct contrast to the positivist paradigm when measures are taken to render the researcher invisible through standardisation. Here, the critic or researcher is an integral and invaluable part of the research process. Therefore, no two critical commentaries will be the

same, just as no two critics are identical. The commentaries will, however, share a unity because they are based on the same portrait. Fish and Coles (1998, p.211) make this important point that all criticism must be related to the portrait and remain true to the vision within that portrait. Even though the criticism bears the personal hallmarks of the critic, the basis from which the criticism originates is the portrait and not their own personal agenda. The portrait and its creator, the artist, set the agenda. Eisner comments:

> Thus every act of criticism is a reconstruction. The reconstruction takes the form of an argued narrative, supported by evidence that is never incontestable; there will *always* be alternative interpretations of the 'same' play, as the history of criticism so eloquently attests. Further, even the qualities described in any critical account are not necessarily either all that could have been described or those that other critics might have described. In short, selection is always at work both in the perception and the critical portrayal of what has been seen. (Eisner 1998, p.86, italics in original)

Therefore, a critical appreciation of the portrait of Elsie written by another practitioner would be quite different and yet should still retain similarities. For instance, a different professional, such as a nurse, would see things from a different perspective, and may well choose to examine different related issues arising within the portrait. The traditions of that profession, although sharing many similarities with medicine, are nonetheless significantly different. This would give a different 'flavour' to the commentary. Even if another doctor wrote a commentary, there would be major differences because of their own personal background and experiences. A major theme that arose as I brought this work together is the inseparability of the person of the practitioner from their practice. I will discuss the importance and impact of this further as I draw this work to a close.

One aspect that I think would have added significantly to this work, would have been to collect portraits of this piece of practice from the practitioners involved. Indeed, were I to embark on a similar project again, I would do that, as opposed to conducting interviews with the practitioners. This would facilitate each practitioner to

explore the artistry within their own and their colleagues' practice, as opposed to me, the researcher, primarily doing this. Of course, obtaining these multiple perspectives could be regarded as triangulation. An argument could be made that this should be seriously considered to add reliability to this genre of research. This is a point I take further in my concluding remarks in this chapter.

However, given the developmental nature of this work, it would not have been feasible to collect portraits from the practitioners involved. Firstly, at the outset I was not aware that this methodology would develop, and the choice of interviews was appropriate to the original conception of this study. Secondly, by the time I realised I needed to explore the artistic/holistic paradigm, it was unrealistic to return to the practitioners to ask them to then produce portraits. Thirdly, in this study I am primarily researching my own research practice as opposed to the episode of clinical practice, which is instrumental to this.

The Narrative

Eisner calls the commentary 'an argued narrative'. This is an apt description, and certainly related to my experience as I engaged in this work. The commentary is a narrative about the portrait and through that professional practice. I was endeavouring to make sense of the portrait, and place it in context within the medical profession and other professionals' lives. Donald (1998 p.20) states, 'narratives give us the capacity to navigate and to order our senses and thereby the world'. The purpose of the critical commentary is to enable the audience to make sense of the portrait and its relevance to their lives and understanding of professional practice.

I certainly experienced the critical commentary as an argued narrative or a reasoned argument. An analogy that I found particularly useful in understanding this process, was to liken the commentary to the barrister presenting a case in a court of law. Multiple sources of evidence are used to support the case, and then the audience, usually the jury and the judge, decide on their opinion. In all of this, judgements are being made. Artists make a judgement about the practice they portray, the critic forms a judgement concerning the work of the artist and ultimately, the critic's audience will form their own judgement. Life in general is about forming continuous

judgements or opinions. Yet so often in science we overlook this important aspect and talk of evidence as 'hard', implying that it is irrefutable and therefore no judgement is necessary in appraising it or using it. Downie and Macnaughton (2000) argue this point strongly in relation to the view of evidence within medicine at this current time. Critics present and argue for their evaluation, this is what I have done within chapters three and four. My personal evaluation is fundamental to the criticism, and an important resource in the production of the commentary.

Sources of Evidence

My experience in this work was that the sources of evidence and their relevance arose from reflection on the portrait, which is also reflection on the original practice. I shall examine the process of reflection on practice in depth in chapter eight. Richardson (1998) refused to adopt a model of reflection, but engaged in 'a process of reflective inquiry'. This sums up well for me the nature of the critical commentary.

Eisner emphasises that no evidence is incontestable. This must be borne in mind when reading any commentary. There will always be other information, opinions or personal experiences available to further inform the commentary. The purpose of my critical appraisal is to open the eyes of my audience, to see practice from a fresh perspective, and to promote further reflections and debate concerning it. The commentary is not and does not seek to be an exhaustive and final review of any aspect of practice. Furthermore, practice, and the professions to which it relates, are not static but are continually evolving. One of the major contributions this type of work will have is to review the traditions of a profession and stimulate its ongoing development. Fish states:

> …and through this to consider the vision of practice enshrined in the portrait in relation to new ways of seeing and working in that profession. Only then will the significance of the understandings achieved become clear. Only then will those understandings be related to future possibilities.
> (Fish 1998, p.251)

The vision of practice is significant for the future, both for individual practitioners and the profession as a whole. Conveying that vision is also important for those outside the profession. Fish and Coles (1998 pp.6-10) proposed this as a means to combat society's misunderstanding of professional practice.

The reflective process means, as Fish calls it, allowing the portrait to make its impact. I had to allow time to view the portrait in its entirety, before rushing to consider parts of it or issues raised within it in detail. Firstly, I had to comprehend for myself a sense of the vision the portrait portrayed about practice. Then, and only then, I was able to begin looking at different parts of the portrait in detail. Just as I described mulling the case over in clinical practice, a similar process ensued in preparing the critical commentary. Some of the important aspects were not immediately obvious, and others that initially seemed important, later receded into the background.

The evidence used within the commentary came from a wide number of sources. One source was my personal experiences and expertise as a practitioner. In our current climate of evidence-based medicine, it is easy to forget the value of years of experience. Research by Schmidt et al. (1990) using a cognitive approach shows that, without realising it, medical practitioners store away memories of the patients they see and their stories. Not all of them are available to our consciousness, but they do contribute to the schema we form, and these influence our ongoing practice. Downie and Macnaughton (2000) discuss the importance of anecdotes that doctors share with each other about some aspect of practice, and often this triggers reflection on it. These two examples are given to demonstrate just how central our past experiences are in informing our practice today.

A critical commentary could be based largely on the practitioner's experience, and from this an evaluation or appraisal of the portrait given. I think this is most likely to be appropriate when the critic is also the artist. Hillier's (1998) case study is an example of this. Although Fish and Coles later offer a critical commentary on each of the case studies in the collection, they also make the point that the contributors were asked to portray the episode of practice and critically comment on it. The two were combined. Indeed, I think this would be ideal for the individual practitioner in continuing professional development, and could take the form of a journal. The

commentaries/case studies could be further developed with additional sources of evidence at a later date, if this was appropriate.

Deliberation with other people was an invaluable source of evidence. The discussions I had with the members of the multidisciplinary team focused on important aspects of the specific practice and on the wider issues. My supervisors have been critical friends in this and helped me to develop my thoughts and to consider alternative perspectives. Family and friends who listened to me and offered their perspectives have given me important contributions.

Literature was another source of evidence. As you read literature you deliberate on it and relate it to your own experiences. I am adopting an inclusive view of literature, not only research papers but also relevant books and articles, which can include fiction. I discuss this in more detail in chapter eight. The next section looks specifically at some of the uses of literature within this type of work, because there are some significant differences from the usual expectations within research practice.

The work I had already done on Elsie's case study in the interpretative paradigm did contribute, although indirectly, to the critical appraisal. The thematic analysis I undertook on the interviews to build up a needs analysis helped me to compare this with the issues and needs that arose in the clinical practice. This could have been included more formally in the critical commentary but in this instance I did not feel it would have been appropriate for my intentions. This again illustrates the point that the artistic/holistic paradigm is inclusive of other paradigms, if appropriate to the work. Fish says:

> Critical appreciation then, is a process in which an activity or an object is responded to critically in order to understand it by any and as many means as possible, but which accepts that there may always be more means to understanding it than have been operated. This process seeks to consider the activity or object from many points of view, balancing pros and cons, seeking to set it in a context that helps to make sense of it, seeing in it meanings beyond the surface and seeing it as representative of something beyond it.

(Fish 1998, p.102)

This sums up many of the preceding points I have made and emphasises that many and diverse means can be used if this helps in understanding the subject or the portrait of the critical appreciation. I have used many and diverse means to contribute to the appreciation, this has included literature, which might be expected but also conversations I have had with friends, which may surprise my audience.

Before leaving this section on sources of evidence within a critical appreciation, one area not to be overlooked is the use of figurative language, in the same way that it is acknowledged as useful within the portrait. There may be times when the critic wishes to illustrate the vision further, or when they are considering ineffable aspects of the portrait that require the use of figurative language to be conveyed. This then becomes a valuable piece of evidence of the ineffable in the arguments put forward by the critic. Notably, in the critical appreciation of the portrait of research practice, including this chapter, I have used figurative language in several places. One example is in chapter one where I described the journey as like walking through fog. Each time I have used figurative language it has been to express something of the ineffable in practice.

Use of Literature

There is a difference between the use of literature within the critical appreciation and the rest of the thesis. The critical appreciation is a reflection on practice and therefore literature is used to facilitate and expand this. It includes a critical appraisal of the literature but this is not the main function and it is not intended to be a comprehensive critique of the literature. The use of the literature is to serve the reflections on practice, not the other way round. The aim in this part of the work is to facilitate practice through practitioner research i.e. firmly practice-based not research to be applied to practice. The two can appear similar but there is a subtle difference. This means that the use of literature can vary between different parts and vary over time on the same topic. For instance, when first reflecting on a topic, it may be more like discovering an as yet unappreciated scene or landscape and the literature discovered adds colour and texture to the scene. This is an apt description of the

situation I found myself in during my reflections on healing. It is a topic that up until this junction in time I had not had the time or opportunity to consider. Undertaking that piece of the critical appreciation felt as if I was on a voyage of discovery.

The work enriched my practice as I came to appreciate healing and my role as the healer. For me, these insights gave substance to areas and views of my practice that up until that point had been nebulous and unarticulated. In fact, if anything, I would not have dared to voice them in the current climate prevailing in the medical world. However, having now carried out this piece of work, I am able to articulate and value these insights for myself, and feel confident to voice them within the wider arena of the medical world. Very likely, should I return to these reflections at a later date, my use of the literature may serve quite a different purpose, in line with the ongoing development of my practice in this area. This is demonstrated in the sections discussing reflection in and on practice in chapters three and eight respectively. In these instances I was acquainted with this concept in my practice over several years, and engaged in refining my understanding and usage of it. Therefore, if I liken it to a journey, I was no longer at the point of discovery but at a place of surveying and evaluating the landscape in more depth. This demonstrates my earlier point; whatever methods are employed, in this instance the use of literature, it is to serve the aim of refining and developing practice. The appraisal of the literature is not an end in itself, which would be entirely legitimate in an alternative genre of research.

It would be prohibitive and impractical to complete an exhaustive critical analysis of the literature on every topic for reflection that might arise within practice. From purely practical considerations, such work would require most practitioners to withdraw from practice for a period. This would hardly adhere to the model proposed in the artistic/holistic paradigm but would mean a return to the elite in university, or similar settings, being the only practitioners with the opportunity to carry out research. The process must be flexible and adaptable to the opportunities and needs of the practising professional. There may indeed be periods when the practitioner has the opportunity and feels the issue justifies an exhaustive critical appraisal of the literature, for example Andrewes (1998 pp.182-200). At other times the practitioner may feel the issue requires personal reflections only, with no reference to the

literature, for example Hillier (1998 pp.126-138). Both these approaches are valid because they develop the practitioner's practice.

The aim is the development of practice, which is not a static, one off event. Rather, it is an ongoing process continually changing and evolving. Unsurprisingly therefore, this process is mirrored in the activities contributing to professional development. The reflection is continuous and evolves over time. This is demonstrated in the variable use made of the literature within the critical appreciation in this work.

Conclusion

I have endeavoured to illuminate the factors involved in the production of a critical commentary and to relate them to my experience in this work. In concluding this section, I consider the issue of reliability in this work because this is quite different from the positivist and social science paradigms. Fish states:

> Here, in working over the drafts, and in the detailed reference to the portrait and commentary, care in the use of artistic and critical processes ensures rigour and promotes accuracy of detail *and spirit.* (Statements which strive for cold fact often fail to capture that deeper truth-truth to the spirit of the matter.) All this is also true of the various points at which reference is made to the wider world of professional theory and practice. The shiver of recognition by the reader is a strong indication that this work has the authority of realism.
> (Fish 1998, pp.252-253, italics in original)

The reader cannot expect to find the same outcomes or evidence of reliability that would be found in a different genre of research. Confusion is most likely to occur with the social sciences. On the surface the two types of work can appear similar, but on closer scrutiny are quite distinct. Rigour depends on remaining true to the spirit of the practice and the portrait that arises from this. As Fish points out, the spirit of the matter goes beyond the cold facts, and that is why this paradigm is needed to fully explore professional practice. The response of the reader is important in this regard, in much the same way a person responds to truths in a novel or a play. The portrait

and the critical commentary must always be rooted in the original piece of practice even though, out of this, wider issues are explored.

ETHICAL ISSUES

I now look at some further ethical issues that arise in this type of work. I have already discussed many of the specific issues that had to be addressed when this study was embarked upon and I do not intend to repeat those here. Rather, I am going to relate this to the wider debate about ethical research and particularly look at some of the implications for future work in this paradigm.

General Principles

There are codes of ethical conduct within research that the researcher must be aware of and comply with. It is important to be aware of these and the principles that underpin them. I, of course, had to ensure that the work I undertook satisfied these codes right at the outset of the research. Quite rightly I had to demonstrate these, both to proceed with the study within the NHS and for the work to be registered for a higher degree with the University.

As a medical practitioner, this research had to be approved by the Local Research Ethics Committee, which is governed by the Central Office for Research Ethics Committees (COREC). This body was set up by the NHS to ensure all research within the NHS is ethical and, in particular, that the rights of patients are protected. The power relations that are inherent in the practitioner-patient relationship must not be overlooked, and this is an issue I discussed in the doctor-patient relationship. The dynamics of this power imbalance are even more likely to be evident in a research setting, and this is why there needs to be close scrutiny and appraisal of all proposed research. I had to be aware of Elsie's vulnerability both because she was in the role of a patient and she was acutely distressed. I was clear that her needs had to take priority if there was any clash of interests with the research.

As I discussed earlier, this study is educational research and it is therefore appropriate for me to take into consideration the British Educational Research

Association (BERA) Ethical Guidelines, which were developed in close association with the American Educational Association. The founding principles on which the BERA Guidelines are based are:

> The British Educational Research Association believes that all educational research should be conducted within an ethic of respect for persons, respect for knowledge, respect for democratic values, and respect for the quality of educational research.
>
> (King Alfred's College 2003, appendix 7)

This principle summarises well the issues that a researcher must be mindful of throughout their study and the use of the word 'respect' succinctly conveys the attitude required of the researcher. This I felt was particularly relevant to the study I undertook and perhaps more appropriate than the local ethics committee because there were many colleagues involved and I would argue that this was educational research in which they took part. As they shared their thoughts and sometimes very personal information with me it was essential that I respected them and the information they shared with me. For instance they had the right to ask for anything they said not to be included in the study. When one practitioner shared some very painful personal details with me, I think both because of the nature of the research interview and because I am a psychiatrist, I was very clear that this was confidential.

In addition to these codes, this study had to comply with the Data Protection Act, which came into force in 1998 and covers the use of all personal information. Personal data used within research is subject to certain conditions under section 33 of the Act. These conditions are different to those for personal data held for other reasons. However, in the use of personal data for research purposes, they specify two important 'relevant conditions' that must be adhered to, namely:

- that the data are not processed to support measures or decisions with respect to particular individuals;
- that the data are not processed in such a way that substantial damage or substantial distress is, or is likely to be, caused to any data subject.

(King Alfred's College 2003 appendix 7)

In conducting this study, it was important for me to be explicit that I was not involved in the clinical care of the patients who participated. The information I collected was not used within their care. The discussions with the practitioners were to elicit their views not to influence them with mine. Indeed, the reflections within the portrait were largely formulated after the episode of care had finished and certainly the case was not discussed with members of the team until that time.

Although I was very clear from the outset that this study complied with all the codes of ethics I outlined above, as the work proceeded I was aware these codes in themselves were never sufficient to ensure the principles on which they were based were upheld. This, I felt, was even more evident in this work because of its developmental nature. I couldn't after all predict exactly how the study would evolve at the outset, therefore there would be potentially many ethical dilemmas arising unexpectedly throughout the course of the work. On reflection I sensed the issue revolved around capturing the 'spirit' of ethical or moral research. This led me to seek out further clarification from the literature.

I would agree with Punch (1998), Pring (2003) and Sikes & Goodson (2003) that ethical codes in themselves are just guidelines and that they can give a false sense of security. If ethical codes become a checklist to be completed with little or no thought given to the moral basis of the research, then those codes become counterproductive. Sikes and Goodson state:

- We think much research practice is based on the understanding that, as long as a code of ethics is adhered to, then it is 'moral'. In fact, this view reduces moral concerns to the procedural: a convenient form of methodological reductionism.
- We think research practice is immoral if it is mechanistic and applied in a technical manner without regard for the specific conditions and circumstances of each particular research context.

(Sikes & Goodson 2003 p.48)

The two fundamental points these authors bring out here are: one, research needs to be moral, and two, this is not a mere technical issue. Research practice needs to be moral practice in the same way that professional practice is a moral endeavour. Carr (2003) argues this connection clearly and refers to the principles put forward by Aristotle. Therefore, in the same way that I have clear moral or ethical principles in my interactions with patients in my professional practice, these are equally pertinent in my research practice. In addition, I need to be clear of the moral basis of the research, and this demands more in-depth consideration than adherence to a code. If I am conscious of this moral basis of my research there will be no question of my priorities being anything other than the good of the participants, patients or staff. Indeed, I would contend this offers them far better protection than any code of practice could possibly hope to.

Regarding the second point, in the same way that professional practice is not just a technical matter but is a moral endeavour, so is research. The 'practical philosophy' of Aristotle is still the key foundation. Carr (2003) discussed this in relation to educational research and makes the point that 'practical philosophy' seeks 'to discover the nature of the good society and how it was to be realized' (p.13). Likewise in medicine the goal is to improve the health and well being of both the individual and society as a whole. These deliberations influence both the research undertaken and the treatment of participants who become involved. This needs to be at the centre of all research we undertake, and if this aim isn't central then that research is amoral and unethical. In relation to this particular type of enquiry, Fish and Coles (1998) emphasise its basis within a 'practical enquiry' or tradition of 'practical philosophy'. If we keep this foundation in mind, we will, I believe, find all the requirements of codes of ethics being fulfilled, and going beyond this, a spirit of ethical research will be exhibited.

In the same way that professional judgement is central to professional practice, judgement is central to research practice. Principles and codes of practice can only be guidance; they cannot cover every eventuality as much as we might try to ensure that they would. Punch (1998) discusses this at length in relation to the particular dilemmas encountered in participant observation. It illustrates the unpredictability of

human existence, which cannot be eradicated from research but has to be grappled with. As Pring (2003) points out 'same principles, but different context, requiring different deliberations about the application of principles' (p.55); each research situation is unique and the researcher has to exercise their judgement in ethical matters. Throughout my study I had to keep reassessing whether my work was ethical or not, each context was different. This was true right up to the end as I wrote the thesis. I included my reflections on my practice in general, as well as reflections on the episode of practice in particular, that practice includes others as well and I had to judge for each of those examples whether or not it was ethical to include those thoughts. There was no set rule applicable to all of the situations.

The final point in this general discussion about ethics within research is the 'disposition of the actors' (Pring 2003 p.63). In other words, irrespective of the codes or principles concerning the ethics of research, the most important factor is the principles of the researcher themselves. It is not about what they do, or say they will do, but about their beliefs and value systems. Again, this relates to the 'iceberg of practice' (Fish and Coles 1998 pp. 305-306) and those deepest layers that fundamentally influence practice. The importance of values and beliefs within research practice is emphasised by the Committee on Science, Engineering and Public Policy (1995). Based in America, the Committee takes a positivist view of science and research, yet in their publication they devote a whole section to values and beliefs. If our theory is to respect the individual, then in practice we will be aware if we are about to infringe that respect, even if there is no obvious breach of some code of practice. This is a better safeguard than any number of rigid codes of practice enforced by an external body. I am not suggesting codes of practice are unnecessary, just insufficient for truly ethical research.

One way of promoting this disposition put forward by Pring is to foster the virtuous research community. This acknowledges the need for a social context for all human endeavours, and in this particular instance, for critical dialogue to occur. There is a need for us to facilitate a spirit of criticism, not destruction, in our practice to ensure the moral foundations are protected, especially in the arena of research. I was fortunate to be part of a virtuous research community in fact; this was a valuable experience for my own professional development. Primarily the critical dialogue

occurred with my supervisors but also included the wider research community as well as the clinicians with whom I undertook this work. Their ongoing critical appraisal was essential both for the development of the study but also its ethical ethos. My experience certainly underlies the fact that research is a human endeavour within a social context and none of us can afford to forget this.

Deliberations Regarding Future Work in this Paradigm

This study has taken the form of a specific piece of research within the artistic/holistic paradigm and has been submitted for a research degree. Therefore, in many ways, there has been a set format to adhere to regarding ethical approval and guidelines. However, it will be apparent from the discussion so far that work within this paradigm can take many forms and some of the ethical boundaries may not be so clearly apparent. These are the topics I now briefly consider. I will not present definitive answers, but my deliberations on these issues are to promote further discussion among my fellow practitioners.

Perhaps the most contentious issue is deciding when this type of work constitutes 'research' in the sense normally understood within medical practice that would require formal submission to a Local Research Ethics Committee (LREC) for approval. My own experience in relation to another small survey study I was involved in as a trainee was that there was no consensus view between different LRECs. One LREC required this survey of staff members to be submitted in the usual way for approval, and another adjoining LREC considered this unnecessary.

Work within this paradigm can be large or small scale. The work can take the format of a learning portfolio or a reflective journal to contribute towards the professional's ongoing development. Indeed, as I comment in the next chapter, this is something I can see myself continuing to do for my own development. Given that this involves a portrait of an episode of practice, it will probably involve reference to a patient with whom that practitioner has been involved. Therefore, before embarking on this, should the practitioner be seeking informed consent and submitting this to the LREC? At this level, it would seem burdensome and unnecessary for all concerned. Not least, the LREC would become inundated and there would be an argument that

all case conferences or discussions between practitioners would then need to be submitted. This is clearly untenable. Equally, I do think about my patients and form judgements based on this, not all of which I would deem appropriate to discuss with them. As this work has clearly demonstrated, this is an integral part of my professional practice. Discussion and deliberation also occur between colleagues, again important, if underrated, parts of professional practice. This includes educational activities such as case conferences, held regularly in most specialities, and informal but nonetheless valuable discussions.

Therefore, where should we place the dividing line? My opinion is that if the reflections are going to be published or placed within a public arena, then serious consideration should be given as to whether it is then 'research' that needs formal ethical approval. However, as I have argued earlier, each situation will need to be considered and debated individually. Perhaps a useful suggestion would be that if there are doubts then the advice of the LREC should be sought. Nevertheless, if formal ethical approval is not required, it does not obliterate the need for ethical issues to be given due consideration, and perhaps places a greater responsibility on the clinician to ensure this. Such principles are no different to those underlying professional practice, which after all is exactly what this type of inquiry is.

Conclusions

The importance of the ethical principles underpinning professional practice has been considered, with particular reference to research practice. This relates back again to the moral basis of professional practice, which was considered in detail in chapter four, and highlights the importance of the person of the practitioner, in whom reside deeply-embedded beliefs and values that will continually inform their practice.

CONCLUDING REFLECTIONS

In these chapters, I set out to critically appraise my experience of using the proposed artistic/holistic paradigm. This was from the perspective of a practitioner researching clinical practice and, I would suggest more importantly, research practice in the service of the practising practitioner who seeks a means to continually refine and

develop clinical practice. From this work I conclude that this is an important and valuable step forward for practitioner research. In both areas of study, clinical and research practice, it has proved useful in the development of my own practice. Likewise, I believe it has the potential to be useful for all practitioners in their ongoing development.

The strength of this approach appears to lie in three major areas. Firstly, it enables the exploration of the artistry within practice, which is unique to the artistic/holistic paradigm. As I discussed in chapter one, Eisner (1998) argues for the appreciation of such artistry within educational practice but does not develop fully the means to explore it. However, I think his work is close to the proposed artistic/holistic paradigm; there are many similarities, but also significant differences. His emphasis is on the production of an educational criticism, which is the public portrayal of the judgements of the connoisseur. This basis is virtually identical to that of the critical appreciation, and I have used his work to promote the concepts of connoisseurship and criticism within the artistic/holistic paradigm. The structure of the final piece of work he suggests combines both the portrait and critical appreciation of practice seen within the artistic/holistic paradigm. This is the form adopted by the contributors to Fish and Coles' (1998) work. In his discussion of the description necessary to convey adequately the subject matter being considered, he states:

> Doing so requires artistry in the treatment of narrative language, and, as I have already indicated, this achievement means shaping the text, hearing its cadences, selecting just the right word or phrase, employing apt metaphor, and on rare occasions creating neologisms that do some epistemological work.
>
> (Eisner 1998 p.89)

This has many similarities with Fish's (1998) writing. I would contend that the descriptive pieces of work Eisner encourages his readers to produce are in fact portraits of practice. Unfortunately, for me, he doesn't acknowledge them as such directly. There is an inference of this later in his work when he compares what he refers to as an 'educational criticism' with what Lightfoot (1983) calls a portrait (quoted in Eisner 1998, p.189).

Terminology, though relevant, is not where the significant deviation arises between Fish's and Eisner's work. The structure and therefore the means of production of the educational criticism put forward by Eisner consist of four elements. These are description, interpretation, evaluation, and thematics. The grounding of these processes is clearly within the established qualitative methodologies and well illustrated in texts such as Denzin and Lincoln (1998), Miles and Huberman (1994) and Patton (1990).

In this study, the basis of my work for the portrait did indeed come from an earlier thematic analysis of Elsie's needs. Although I consciously put this aside when I changed direction, nonetheless the thematic analysis was an important contribution to the portrait. I cannot determine how different the portrait would have been without it. However, the thematic analysis was not essential for the production of a valid portrait. It would just have been different.

By proposing the adoption of the process used by artists, Fish opens the way for any or all of the means available to be used if useful. Explicitly adopting artistic processes enables artistry in professional practice to be explored. Eisner, in my view, limits this exploration by specifying a means that is not exclusive to the exploration of artistry, although it may be useful in informing such work, as it was in my study.

The second strength of the artistic/holistic approach is that this paradigm/methodology is inclusive of other methodologies and views of truth. Therefore, an episode of practice can potentially be explored from all perspectives, which closely relates to the preceding discussion. This methodology would be well suited to an extensive review of a piece of practice. For instance, in Elsie's case, there could have been a review of the literature to look at the evidence base for the treatment options, a needs analysis using qualitative methodology, incorporation of the development of a theory of needs assessment in the clinical encounter, as well as the specific work presented here to examine the artistry in this episode of professional practice. Within this study I chose to focus on the artistry and the means to explore this.

There is a strong argument for the adoption of multiple perspectives to gain a deeper understanding of a situation, known within qualitative research as triangulation. This has been advocated in qualitative research to promote rigour. One area worthy of further consideration, especially in the use of this paradigm in larger scale work, is the use and role of triangulation. Without a doubt, much would have been added to this work if I had collected portraits of the episode of practice from the practitioners involved and then examined the similarities and differences. I would emphasise, however, that triangulation cannot be the main means of reliability in this work. Reliability, or rigour, as Fish (1998) emphasises in this paradigm depends primarily on the writing and capturing of the spirit of practice. Furthermore, it should not detract from or be seen to invalidate the use of this methodology in smaller scale projects for individual practitioners. This relates closely to the next strength of this type of work.

The third strength is that this paradigm is flexible and suitable for both small and large-scale projects. This flexibility makes the paradigm eminently suitable for use by practitioners for continuing development and can be tailored for their needs and the area of practice they seek to develop. It also has the potential to contribute significantly to the evidence base of professional practice.

In conclusion, I would argue that this paradigm/methodology is an important development and is particularly well suited to the needs of the practising clinician. Its main contribution will undoubtedly be, I feel, in the ongoing development of the individual practitioner's practice, in other words continuing professional development. This has certainly been my own experience. However, there are other important areas in which I would suggest this paradigm/methodology can be extended and should be further investigated. For example, it can explore directly the artistry within practice as well as encompass the other available methodologies, and is therefore ideally suited to an in-depth review of an episode of practice. In fact, this type of review could be argued to portray true evidence-based practice. Another potential area for the use of this work to be explored in is team building. If the different practitioners were to each produce portraits of an episode of practice, this could be instrumental in their appreciation of one another's work, and therefore their ability to work more harmoniously. This type of work would, I feel, bring a

realisation of the various but important contributions different professions make to health care, and is a strong argument against the generic health care worker.

There are many ways in which this paradigm/methodology has the potential to be further developed. The work I have presented here and my own experience is just one example. The important aspect, which must be comprehended, is that a creative process is used to explore another creative process. Such a creative process encompasses within it uncertainty, and that uncertainty must be tolerated. We should also remember that in our everyday practice we tolerate uncertainty, whether we acknowledge it or not. The rewards however for tolerating it are in my view well worth the risk. Artistry within practice cannot be fully explored and appreciated unless we embrace this creative process to do so. Until now, the artistry that has been revealed within research has been almost incidental to the main thrust of the work and at times incidental to its main purpose. Now, however, that artistry can take centre stage. This offers the potential for a much deeper understanding of the professional judgements that underpin our practice.

CHAPTER 8: THE DEVELOPMENT OF THE PROFESSION

INTRODUCTION

Professional development encompasses medical professionals' development from the moment they enter medical school to the moment they retire from medical practice. The individual's development is, of course, paramount to the profession, but equally important is the profession's collective development. I intend to reflect on both these aspects and the contribution this research can make to the process of each of them. The views expressed are personal to me, although I do draw on relevant literature I am not presenting this as an exhaustive critique, rather the strength of this work arises from its basis within my own practice and experience.

CONTINUING PROFESSIONAL DEVELOPMENT

The need for all professionals to keep themselves up to date throughout their careers is well recognised and an area that is becoming increasingly regulated by the government. Medical practitioners spend most of their working lives in the postgraduate phase of their careers. In the rapidly changing world, there is no possibility of learning all you might need to know in those few undergraduate years. Schon (1971), in his aptly titled work 'Beyond the Stable State', makes the point that the rate of change within our society has rapidly increased so that everyone needs the capacity to adapt continuously within their lifetime. Even though continuing professional development is predominantly seen in the context of postgraduate ongoing development, it actually commences on the first day at medical school. This concept, and the means to promote it, needs to be incorporated into the undergraduate years.

Equally, a point I have argued in this thesis is that most learning occurs through experience. This learning is an ongoing process and I think is more aptly called development. Initially the term continuing medical education was adopted by the profession. Richards, in her editorial in the *British Medical Journal,* points out the contrast with professional development:

> The fact that most current models of continued medical education fall well short of the ideal has fostered the conceptually broader paradigm of continued professional development. While continuing medical education is largely designed to plug supposed gaps in knowledge, continuing professional development is rooted in self directed reflection and learning in practice.
> (Richards 1998, p.246)

The point she reiterated was that enforcing rather than encouraging doctors to take part in continuing development is unlikely to produce the hoped for benefits. Continuing professional development needs to be rooted in self-directed learning. This doesn't mean that professionals are unaccountable for their development. In fact, I would suggest that where they do take the responsibility for their ongoing development, they are actually more accountable.

Continuing medical education adopted a technical-rational stance, whereby the updating of technical skills was all that was largely seen as relevant. This resulted in the need to impart information that the recipients needed to soak up. The net result was the requirement to accrue the right amount of hours sitting in lectures. Davis et al. (1995) reviewed the trials looking at the effectiveness of continuing medical education strategies. Their results showed that the favoured didactic teaching, usually presented in a lecture format, had little direct impact on improving physician performance. There is recognition now that ongoing learning through a professional's career needs to encompass far more, and the term continuing professional development (CPD) has been appropriately adopted. Brigley et al. (1997) discuss this change of emphasis to CPD, highlighting its self-directed learning with the promotion of reflection, to enable learning to take place and to be relevant to the practitioner. The GMC definition of CPD is:

> a continuing process outside formal undergraduate and postgraduate training that allows individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behaviour.
> (GMC 2003, A1)

This definition acknowledges the necessity to include more than just technical skills for good medical practice and appears to relate to the iceberg of practice (Fish and Coles 1998, pp. 305-306). A little later in the document it states 'learning from peers and patients within the doctor's workplace can be particularly effective' (A2). However, the focus remains on surface qualities, the easily visible parts of the iceberg. There is a need to access the deeper, less accessible layers of the iceberg that arguably are more influential in our professional judgements. Certainly this could be encouraged within an appropriate reflective model. Day makes this important point:

> *However, as we have noted, reflection is a necessary but not sufficient condition for learning. Confrontation either by self or others must occur.*
> (Day 1993 p.88, italics in original)

Reflection must be accompanied by critical appraisal for learning to result. Practitioners have to question their ways of doing things, whether there is an alternative and preferable way. Equally, a critical appraisal can, and should, result in the recognition and appreciation of good practice.

In the course of this study and in my discussion with fellow practitioners I have come to believe that the professional's development is ensured if a life of reflective practice is followed. I have purposely used the terminology regarding a way of life as I think this is intimately bound with the life of practice, 'bios praktikos'. A life of reflective practice will open opportunities for all kinds of educational activities that might be listed as needful for the practitioner, such as evidence-based medicine activities, practical skills updating and critical inquiry. However, this approach will also encompass other aspects that are easily overlooked or difficult to fit into exact educational pigeonholes, such as professional artistry. Most importantly, reflective practice is practice led and directed. This focus incorporates the whole view of practice, which is far greater than the sum of the individual parts.

Reflective practice fosters a recognition and critical appraisal of the traditions of our practice. It enables us to become part of this body of practitioners and to develop the

practice further. This occurs through dialogue and discussion. In ancient societies the traditions, for instance those of the healer, were passed on and extended through debate. The reliance was on oral culture rather than the written word, something that is still reflected within medicine. This debate and critical appraisal of practice by practitioners, to transmit and extend the traditions within which they practice, has always been, and continues to be, central to this purpose.

I would suggest that many of the elements of professional development and regulation, which are being enforced politically on the medical profession, rather than enhancing development of the individual practitioner and the profession, will stifle this process. Practitioners are overwhelmed by paperwork to prove they have a personal development plan, that they are being appraised, that they audit their work and that they are fit to be revalidated. There is no time or energy left for meaningful debate to take place between practitioners. We are in danger of getting caught up in a paper exercise arising from a political myth of central control and certainty. The medical profession, in my opinion, is caught in the tension between the traditional means of debate to further their practice, and the imposed misguided political means to control and regulate practice. Interestingly, Freidson (1994) once argued against the need for professionals in society but then acknowledged they were the best vehicles through which to achieve certain aims within society. He considers ways of managing the professions and suggests they need to be nourished and developed, discounting the role of bureaucracy. Given his earlier views, you might expect him to favour close bureaucratic control.

Despite the tension we are experiencing between regulations, with all their attendant bureaucracy, and the pursuit of effective professional development, we must continue to aim for that development. This means developing the traditions of our practice, both within ourselves and as a community of practitioners. I would strongly suggest that reflective practice offers a means to enable this.

REFLECTION ON PRACTICE

This is a learning-based activity that can, I think, be appropriately named reflection on practice as proposed by Schon (1983), but needs to be seen in its fullest and

widest sense. I would suggest that it is not one activity but many on a continuum, all valid and of equal merit.

Purpose

The fundamental aim appears to me at the heart of this activity is the development of practice. This purpose needs to be acknowledged and maintained in all the various forms that reflective practice can take. It is not, I feel, the prime function of reflection on practice to serve the organisation, although of course the organisation is likely to benefit when professionals are engaged in this process. Bolton (2001) discusses the importance of the underlying aims of learning-based activities, and the impact on the learning that arises from these activities. Often in our current consumer-orientated culture, the aims can be focused on the potential gain of the individual or organisation, usually in terms of a qualification or a recognised competency, rather 'than the innate value of the intellectual enquiry undertaken' (p.26). Carr and Kemmis raised a similar issue in their overview of curriculum development, highlighting the ramifications of the underlying aims in determining how any tool is used, in this instance the curriculum:

> …that the aim of developing the cultivated person was now discarded in favour of developing conformity to an agreed image of the educated person (implied by the goals), and that teaching and curriculum become instrumental – the means for achieving these given ends. (Carr & Kemmis 1986, p.14)

The literature points to a difficulty within all professions in that the purpose of education has become the acquisition of a commodity instead of the development of the learner. The distinction is subtle and on first glance may not be evident. Of course, the development of the learner may immediately result in the production of measurable competencies, but what is of primary importance is the growth in the stature of the professional. This growth defies simple measurement or tick boxes. Competencies arise out of this growth but the reverse is not true. The acquisition of competencies and/or qualifications does not foster the growth of a professional.

In today's world, value appears to be given only to things that can be measured. Therefore, it is not surprising that, within the professions, we have come to focus on measurable competencies. The growth in stature, that is a measure of real professional development, can however be recognised and gauged by other professionals. It can also, I would contend, be demonstrated to society in general if the professionals learn to use the appropriate tools. This is indeed the thrust of this piece of work.

A pertinent question in medicine at this time would be: are we seeking to develop professionals or simply well trained technicians? This links back into our view of the professional and the debate, so well articulated by Schon (1983), between professional artistry and technical-rationalism. We must examine our views on this, both as a body of professionals and individually.

In the current climate, which demands revalidation and easily measurable outcomes from professionals, there is a danger that reflective practice could be hijacked to become yet another tool in the service of the regulation of professionals (Richardson 1995). Greenwood (1991), considering reflective practice within a large co-operative in Spain, also underlines this factor, seeing the possibility of reflective practice being used as an organisational device for manipulation. I think, given the importance of reflection in promoting professional development, it is correct for it to be a requirement for revalidation. But its inherent nature and purpose in the service of professional development must not be obscured by an imposed regulatory role.

Characteristics

The concept of reflective practice arose from the debate about professional artistry. Schon (1983) maintains that one of the distinguishing features of a professional, as opposed to a technician, is the professional's use of artistry in practice. In contrast to technical competencies, artistry cannot be taught, but has to be nurtured and allowed to grow. This was the role seen for reflective practice when it was originally proposed. Therefore, from reviewing the origins of reflective practice, I would suggest that a critical characteristic of this concept is to facilitate the opening up and recognition of artistry in practice.

Many health professionals do not recognise the world-view and its accompanying value system that underpins their practice. Health professionals, particularly doctors, who are aware of this world-view, usually discount or underestimate its impact on their practice. Particularly in medicine, we are presented in training with the positivist paradigm. It is never named, because it doesn't need to be in this world-view of science. There is an unspoken assumption that there is no alternative viewpoint which is a credible alternative or challenge. It is seen as the absolute truth and should therefore be accepted uncritically. The very act of not acknowledging the positivist paradigm and examining it conveys its unquestioning superiority. This fosters the technical-rational view of professional practice. As a consequence, many of our practices are based on a technical-rational foundation, without us even recognising this. I would suggest that reflective practice has been embraced within health care but often subtlety transformed to comply with a technical-rational perspective.

Fish (1991) examines quality assurance within education and argues that reflective practice is central to quality. The important determinants of quality assurance are the beliefs and values on which it is based. She examines two exercises that superficially appear to share the same goals. One, however, is appraisal and rooted in the technical-rational view of professionalism and the other is reflective practice rooted in the artistic view of professionalism. These two exercises are very different, with divergent goals and they achieve different ends for the practitioners.

A similar situation occurs with activities that are called reflective practice, and which on superficial examination appear similar. However, when the foundations are examined, their differences become evident. The crucial issue is whether they are based within the professional artistry model of practice or within the technical-rational model. If the foundation is indeed the professional artistry model, then this activity will be seeking to reveal and explore the artistry occurring in practice. The goal is to nurture this artistry within the practitioner. This growth or nurturing can only occur for the individual because they desire it. In contrast, the activities called reflective practice but with their foundations in the technical-rational viewpoint, generally seek conformity to guidelines and often incorporate a supervisory element.

We are often, I feel, left in the unenviable position of believing that professional artistry is being acknowledged and developed because systems of reflective practice have been put in place. In reality, we have just implemented another technical-rational-based procedure genuinely believing it to be something else.

Reflection is seen as an essential component of learning but is often taken for granted (Boud et al. 1985). Neither experience nor formal teaching is sufficient for learning to occur. The act of reflecting has to occur for the recipients to assimilate, or make personal, the learning experience presented to them. When this occurs, learning takes place. If we consider reflection in a more general context, reflection is an everyday occurrence through which we are all continuously making sense of our experiences. Reflection is so much an accepted part of our lives that we take it for granted. This does not mean that reflection therefore occurs effectively at all times, or that it cannot be developed further.

For health professionals, I believe reflection already occurs naturally in a variety of contexts and forms. We need to recognise and value this, including its diversity, and seek to promote and develop it further. This is necessary on an individual and corporate level. It is beginning to be recognised as an important component of continuing professional development in medicine (Brigley et al. 1997; Coles 1996; Fish and Coles 1998; Richards 1998). Indeed, the Royal College of Psychiatrists states that continuing professional development should occur within the framework of reflective practice, which is defined as:

> enabling the practitioner to access, understand and learn through his or her personal experiences and thereby to take appropriate action towards developing increasing effectiveness.
>
> (Royal College of Psychiatrists 2000, p.10)

One major contribution of reflection is the potential access it offers to all levels and aspects of practice, not just the easily identified parts. It allows for a broad and inclusive view of cognition. In the iceberg metaphor proposed by Fish and Coles (1998, pp. 305-306), the surprising aspect is how little (only one tenth) is actually visible above the water line. The vast majority, nine tenths, is the unseen bulk below

the water line that gives it stability. Using this picture, it becomes obvious that if we concentrate on building up the tip above the water and ignore the base, the whole iceberg will become destabilised. Yet so often it is only the visible and easily measurable bits that we concentrate on. In the current climate, with the demands of society and government, this focus is further reinforced.

Important areas to be considered under the waterline are feelings, expectations, values and beliefs. Some of these are deeply embedded within us and exert a fundamental influence on our practice, and yet are not easily accessible. However, this is not the same as saying they are inaccessible, and, with excavation, parts of them can come into view and therefore become open to review. This gives the potential for change to occur at foundational level. There needs to be an acknowledgement of the whole person who constitutes the practitioner and Bolton puts this well:

> the practitioner needs to be aware that they themselves also are whole people – they do not leave their personalities, their souls, their senses of humour, or their fragilities outside the classroom, consulting room or client's front door. And they need to be aware that they take on different roles at different times, just as we all do all the time.
> (Bolton 2001, p.11)

The longer I am in practice, the more I have come to realise that my practice cannot and should not be separated from me, the person. As well as the weaknesses this may bring, there are also strengths.

The essence of professional practice is phronesis or practical wisdom:

> **Practical wisdom** then, appears in a knowledge of what is required in a particular moral situation *and* both a willingness and the capacity to act upon this knowledge.
> (Fish and Coles 1998 p.272, italics and bold in original)

If we accept that practice encompasses more than just technical expertise and includes moral decisions and judgements, then it is evident why we must have to access those processes underlying these deliberations. Richardson's (1998) case study elegantly portrays many of these aspects, as she engages in reflection, not on a piece of practice, but on a personal incident that had ramifications for her professional practice. Indeed, one of its strengths is in emphasising how our personal selves cannot, and should not, be divorced from our professional selves. She is able to oscillate from discussion of formal theory to personal theory, revealing how, for her, both inform each other. The other aspect that stands out for me is her refusal to adopt a reflective model. Instead she engages in 'a process of reflective critical enquiry'. In other words, the process of reflective critical enquiry dictates the means used, not the other way around.

In my own personal experience, using a model as a guide to reflection can be destructive. I recognise that the word 'destructive' is very strong, but on reflection I think it is justified because it does convey my experience. Interview skills training is one example and is a standard expectation within psychiatry. Trainees take it in turns to video themselves conducting an assessment. This is then played back to the group and various set questions asked. The rationale of the questions is understandable, seeking to get the group to focus on what went well first and enabling the person in question to comment. Despite this, it always seemed to me a wooden experience to be tolerated. This was true whether or not I was the interviewer, fellow trainee or the facilitator. In the position of facilitator, I was keen to enable reflection to really take place but the formal protocol always seemed to hinder this. Looking back I wonder whether it was more a problem with us, as the participants, than the protocol itself. Was it insecurity that promoted rigid adherence to the protocol? Did people feel safe enough with each other to examine their practice? I also question whether it was perceived as a chore dictated by The Royal College of Psychiatrists for trainees. Reflective practice can only be engaged in by the participants; it cannot be imposed on people. Bolton comments:

> Giving students set proformas, lists of prompts, questions or areas which must be covered in reflective practice will stultify them, make them passive and feel unrespected. Reflective practice can become

> mere training if the questions about practice being asked and answered are created by others.
> (Bolton 2001, p.26)

This certainly sums up the experience. My feelings were that all the participants did become passive, including the facilitators, and respect was not cultivated by this activity. Relating back to the earlier discussion as to the distinguishing features of reflective practice, I would question whether this model of interview skills training was based on the foundations of professional artistry or in fact the technical-rational view. Bolton, in the quote above, refers to this as 'mere training'. Carr (1995) echoes this concern, warning that reflective practice can become instrumental. Care must be exercised when a prescriptive model is advocated for reflective practice. It suggests to me the search for certainty and definite answers, whereas professional artistry acknowledges the uncertainty and lack of the one and only 'right' answer.

The example I gave earlier, of interview skills training, demonstrates to me the failure of a model approach. This was compounded by its imposition and lack of appreciation of how vulnerable the participants were possibly feeling. Although interview skills are an important area to focus on and develop by means of reflective practice, in this instance, effective and productive reflection was not fostered.

Acknowledging that reflection on practice cannot be prescribed or dictated in advance means accepting and tolerating an element of uncertainty in the same way as it is necessary to do so in practice itself. Reflective practice mirrors professional practice. By its nature, the process of reflection is a fluid and creative enterprise, and you cannot know the end product in advance. Bolton emphasises this in her definition of reflective practice:

> Reflective practice entails an embracing of uncertainty as to what we are doing and where we are going; confidence to search for something when we have no idea what it is; the letting go of the security blanket of needing answers.
> (Bolton 2001, p.15)

Similarly, in writing this thesis I cannot know the end product before I complete it. It needs to grow and develop. I would argue therefore that there are three mirroring processes here: professional practice, reflection on practice and the research process itself.

Although it is important not to be prescriptive with regards to reflection on practice, general principles about its nature and the framework that facilitates its emergence can be determined. I now turn to consider in more detail some of the literature and relate it to my experience as a practitioner.

Principles of Reflection on Practice

Day (1993) discusses the work of Handel who postulated that reflection occurred on three levels within teaching. These were:

- Actions, talking about work and deciding what to do - practical aspects;
- Practical and theoretical reasoning - making this explicit;
- Ethical justification for action.

There are, I think, many similarities within health care. Level 1 would seem to equate with much of everyday clinical practice and, as in teaching, this is where change appears to be encouraged. It is a superficial level concerned with visible outcomes, and is related to the current preoccupation with guidelines. It is also the level on which evidence-based medicine, with its emphasis on the technical-rational view of practice, operates. In many aspects I would also suggest it is quite a safe area for the professional. It enables practitioners to remain quite distant or divorced from their practice. You could compare it to a behaviourist approach within psychology. Here the emphasis is on what you see, therefore as long as the action appears correct, little consideration is given to underlying factors. All efforts are concentrated on modifying behaviour. However, changes resulting from behavioural approaches are found to be short lived and quickly decay, unless accompanying cognitive changes take place. There is a salutary lesson here for health care today.

Day (1993) points out that the busyness culture within schools discourages reflection at levels 2 and 3. There is pressure on being seen to get through more work in less time, and this equates with the notion of being a 'successful' professional. Politicians are continually setting targets. The majority of these relate to waiting list measures; as many doctors continue to emphasise, they have little relevance to clinical need. In fact they introduce a perverse incentive.

In addition to these pressures, society is demanding more accountability from its professionals, which was an issue I addressed in chapter four. This has resulted in increased demands on the clinician's time to prepare the regulatory paperwork. These demands have created an extremely busy culture and, not surprisingly, this discourages reflection on practice. However, these very pressures against taking time to reflect on practice make it all the more imperative that practitioners ensure there is space to stop and reflect. At a time when professionalism itself is under threat, we as professionals need to understand our own practice and learn to convey it to society at large (Fish and Coles 1998, pp.3-10). Reflection at Handel's levels 2 and 3 is fundamental to this endeavour. We need to start uncovering some of the complexities of our own practice and refute the simplified version being pressed on us. Reflection on practice will uncover our theories in use, often revealing the dissonance with our espoused theories. This dissonance can be extremely uncomfortable. It will frequently expose assumptions, values and beliefs that underpin our practice, yet we are rarely even aware of their existence. All of these aspects link into our personal and professional biographies. Not surprisingly then, reflection at this level is seriously challenging. This quality of reflection requires hard work, time, commitment and a willingness to tolerate discomfort. Coles summarises this:

> Articulating one's private theories, and critically appraising them, is rarely part of professional development. We are unused to doing it. It can be difficult and even stressful. Nevertheless theorizing can be highly rewarding for the professional, resulting in enlarging the professional's capacity for making professional judgments. (Coles 1996, p.156)

It is noteworthy that, when I considered the interviews I had with professionals during this study, it was striking just how hard it was to get practitioners to reflect on practice, whereas discussing their reflection within practice, as they considered Elsie's story and the interpretation of it, often occurred spontaneously or with minimal prompting. I think this demonstrates Coles' comment that we are unused to critically appraising our practice. This suggests to me that, as professionals, we need to cultivate reflection on practice in both our own and our colleagues' professional lives. I do not think we can afford to ignore the need to effectively appraise, appreciate and communicate our professional practice. There is a danger that we will not understand the true nature of a professional as opposed to a technician. Society will not appreciate the value of the professional because we won't be able to tell them. If you do not appreciate the value of a costly commodity there certainly isn't any logic in continuing to support that commodity, whether by recognition, education or financial support.

Another important factor in fostering reflection on practice is the role of the organisation, particularly its culture, within which professionals are embedded (Day 1993). Reflection on practice must be valued, and if it is valued then time must be realistically given for it. I sense in the current health care climate reflection is often acknowledged as valuable, but when faced with competing pressures, is the first to be discarded. The commitment is needed within managers of services as well as the professionals themselves.

Reflection on practice, or reflective practice, must incorporate critical enquiry (Carr and Kemmis 1986) if the aim of ongoing development or reconstruction of that practice is to be achieved. Not only must the practice, in all its aspects, be rendered visible, but there must be an examination of it and a willingness to challenge aspects of that practice or be challenged by it. It could be conceived as a critical appreciation of the piece of practice, a concept developed by Fish (1998) within the artistic/holistic paradigm. This facilitates the good parts of it to be appreciated as well as confronting the areas that need revision. For example, in the portrait of Elsie, the depth of understanding and holistic approach to her needs is evident and is a strength to be appreciated within this particular team. However, the reticence, including mine as the researcher, to address the conflict that arose between the Social Worker and

Elsie, reflects a possible weakness within the team to openly approach areas of difficulty. Linking this to the current discussion of the need for critical inquiry of practice, leaves me wondering if this is a problem area for this team. It may originate from many underlying sources. Do we feel safe enough with each other? Does the culture mitigate against this openness? Did we sense that the individual involved would find this threatening? Has it been disastrous in the past?

In acknowledging the need for the reflection as a form of critical enquiry, other people need to be involved at some level to provide feedback and alternative perspectives to challenge our taken for granted concepts. We also cannot ignore the fact that we are part of a professional community so developing practice has to involve one another. Our individual and our collective practice need to be developed or reconstructed. Several authors stress the importance of seeing this reflection on practice as a social phenomenon (Coles 1996; Day 1993).

Models of Reflective Practice

Social interaction can take many forms and it is not always the conventional forms that we immediately associate with a social phenomenon. For instance, I feel that through the medium of literature my own practice has and does continue to develop. Literature, I would argue, is in itself a social phenomenon, involving the author and the reader. Reading about the struggles of the carer of someone with Alzheimer's disease (Heywood 1994; Bayley 1998) or the experience of the person developing Alzheimer's disease (Friel McGowin 1993) enhance my understanding of patients I encounter. Fictional works can also convey insights. McEwan's (1997) novel *Enduring Love* portrays the widespread ramifications of psychiatric illness. A young man by chance becomes the focus of a man's delusional love that gradually evolves to hatred. The artistic account of the damage and confusion that follows for this young man in his personal relationships, and his ensuing frustration as he himself is disbelieved and questions are raised about his own sanity, is very powerful.

The value of this experience for the professional should not be underestimated. It is not possible for us to personally encounter all the relevant situations related to our field of work. Doctors cannot experience every illness they might treat, or every life

experience that their patient might encounter. Yet doctors need to exercise empathy to function effectively. So often, when criticisms are voiced of doctors, the complaint is that 'they didn't listen' or 'they didn't really understand'. There can be many reasons underlying these perceptions, including the basic reason that the doctor didn't understand what it was like for them. Petrone writes of his experiences during and following his diagnosis with Hodgkin's lymphoma in 'The healing touch'. The initial part of this is quoted by Kirklin and Richardson in their book on medical humanities. The whole piece is very moving. I have purposefully chosen to quote a large segment because it expresses so movingly what I would be unable to convey:

> I need to know that this body is my body. And I need to know everything that is happening to my body. But most of all I need to know that you know that within my body there is me.
>
> Healing is brought about not just by medicine. It's not just treatment which cures you, but all that encompasses the human touch. A smile means more than an antibiotic injection, a hug means more than a platelet transfusion. The face – those of my friends, my family, my nurses and yes, even my doctors – shows sympathy, compassion and understanding. This human face contributes so much to the healing of the tortured soul.
> (Kirklin and Richardson, 2001 p.32)

Petrone portrays the longing for human touch or 'connexion', which he illustrates so eloquently. He demonstrates that the human touch is just as central to healing as 'evidence-based' medicine. This human touch, or empathy, is an important area, which I explored in greater depth in the consideration the doctor-patient relationship. The point I would draw out here is that empathy can be fostered for the professional through the medium of literature. It enables the individual to gain the other person's perspective and to reflect on what it might feel like to be that person in that situation; in other words, to stand in their shoes. The literature can encompass both factual accounts of an experience, for instance Petrone quoted above, or it can be fictional. It is debatable whether any 'factual' account can ever just be that; even in the description of an event, interpretations and judgements will have been exercised.

Bolton (2001 p.4) reminds us that 'any retelling will inevitably be affected by the view of the person doing the retelling'.

The role of literature is beginning to be recognised within medicine itself, more so probably at the undergraduate level (Kirklin and Richardson 2001; Moore-West et al. 1998; Sweeney 1998). It does remain, however, a somewhat side issue and is certainly not yet accepted as an equal partner to evidence-based medicine. Unfortunately I feel, in the current climate we often seem to assume that only the truth of evidence-based medicine exists or is worthwhile. As a body of professionals, we need to embrace all forms of truth openly, accepting the limitations of each form, and not being threatened by any of them. Roberts echoes these thoughts in his examination of the role of narrative in severe mental illness. He considered this in the light of a professional world that has come to be dominated by an evidence-based world. He opens his discussion by the observation that:

> the evidence of testimony or opinion has been identified as dirt on the lens of science, which EBM has been created to remove, and its methods are such as to eliminate the complexity of individual variation.
> (Roberts 2000, p.432)

This demands a radical mind shift within evidence-based medicine, and an acceptance that 'objective' truth may not exist in its current definition. In my everyday practice, I and many of my colleagues actually use all forms of truth to inform our judgements. The problem is that we rarely acknowledge even to ourselves the use of these within our everyday practice. This allows important aspects to go unrecognised, and therefore be unappreciated both within and outside the profession. Reflective practice is one important means through which all these facets within practice can be recognised and appreciated.

The value of literature has emerged alongside the growing interest in narrative. There has been a progression from illness stories to promote understanding of the patient's position (Kleinman 1988), to critical analysis of stories of sickness depicted in fiction (Brody 1987) and personal experiences (Kay Toombs 1993) from a philosophical

point of view, to an examination of literature to inform ethical debates (Lindemann Nelson 1997; Hudson Jones 1999).

As well as reading other people's stories, there is a growing interest and development in the use of writing for professional growth. This is seen in both the more 'factual' area, such as case studies and critical incidents (Fish and Coles 1998; Fish 1998), and in the use of fiction (Winter et al. 1999; Bolton 2001). This thesis is centred on writing about professional practice to promote its development, the production of a portrait based on a piece of practice, then a critical appreciation reflecting on it. West, in concluding his work with a group of inner city GPs whom he invited to reflect on their lives with him says:

> Far more spaces are needed where doctors can, imaginatively and collaboratively, generate stories together.
> (West 2001, p.212)

Stories can of course be told verbally and, indeed, there is a long tradition within different cultures of handing down stories in this way. The role of the story teller should not be underestimated even within our 'modern' culture. There is still a strong oral tradition within medicine. Our presentation of cases to each other is a specialised form of storytelling (Montgomery Hunter 1991; Downie and Macnaughton 2000). Even when we communicate professionally by letter, most of us do this by using a Dictaphone. I suspect this leads many of us to engage in reflection on practice more easily and naturally within a verbal medium, and to find the use of the written word quite daunting at times.

It is important for there to be a redress in this balance. This does not mean undervaluing the oral tradition but rather learning to use it and to be comfortable in the written medium as well. If this is fostered within medicine and other professions. there will be enrichment for all involved. Personally, this study has enabled me to learn to use writing to explore and convey my practice. It has enriched my professional life and will, I believe, continue to do so long after this thesis is completed. Rawson considered these issues in relation to inter-professional working:

Practitioners, however, are typically given neither the time nor encouragement to reflect on their actions. In practice there is little literate form of reflection. Practitioner knowledge per se tends to be transmitted and contained only within an oral culture (de Castell 1989). This continues a sharp division of labour between thinkers and doers, the latter left only with pragmatic considerations and anti-intellectual, instrumental thinking.

(Rawson 1994, p.53)

He is suggesting that there is a sharp contrast between the thinkers and the doers. I would suggest the thinker is the reflective practitioner, who is then enabled to become an effective 'doer'. I would also agree that in using the written word the reflections and insights gained by one practitioner can be disseminated to a wider audience and may encourage others to become reflective or 'thinkers' themselves. The written word is also an important tool to be used in challenging the predominant technical-rational view, linked so closely with the evidence-based medicine movement currently present in health care. However, to think that using the written word would ensure that all practitioners become engaged in reflection is too simplistic. The fundamental aspect here, I think, is the practitioner's belief system. It is dependent on them seeing the value of reflection and then choosing to partake in it. This point relates back to the earlier example I cited on video interview skills training. It is a mandatory requirement for trainees in psychiatry but it certainly doesn't guarantee reflective practice.

One important advantage of the written word is its permanency. It allows the authors to revisit what they wrote at a later date and continue to revise it, as it were to have a conversation with themselves. There is a distinct advantage in writing what you feel at the time and then coming back to it later, when often you will see it in a fresh way, and as a result different insights can be gained. Certainly, an aspect not to be overlooked is the space and safety that writing gives to the practitioner, to consider whether or not to share their thoughts with someone else, and to choose thoughtfully who that person might be. By contrast, words can easily be spoken in haste and later regretted at leisure but they can't be erased.

Using the medium of writing also enables the reflections on practice to be shared with a wider audience. Given the current need for professionals to communicate the complexities of their practice to the public, learning to use this medium should not be neglected. Equally, within our own profession we need to record through the written word the dilemmas, the uncertainties, the unanswerable questions we confront everyday to acknowledge to ourselves the true nature of professional practice, rather than the idealised version we so often cling to. I suspect this idealised version can in the end be the cause of disillusionment and, ultimately, broken lives within medicine.

The Interface of Reflective Practice and Personal Lives

Linden West (2001) wrote of his interviews with inner city GPs, and the strength of his work is in demonstrating the whole aspect of their lives. By that I mean that their professional lives cannot be compartmentalised and separated from their personal lives, cultures, genders or biography. I found it compelling reading but at the same time depressing. Occasionally, I felt this to such a degree that I would avoid picking the book up, and sought another instead. The reason for this was the pain and loneliness some of these people experienced, and which I identified with. The most poignant feature was the isolation they all had to deal with, and from their accounts it was costing some of them dearly. Worryingly, I believe this is true for so many of my colleagues, yet our culture demands that it remains unacknowledged.

Healers, because of the nature of their work, need healing too. You cannot face pain all the time without it sometimes getting through whatever defences you usually use successfully. Indeed, there is an argument that if we were never affected by it we would become of no use to our patients. Our personal backgrounds make us vulnerable in certain situations. Recently I found it extremely painful to sit with teenagers, about the same age as my own sons, and explain what was happening to their father with Alzheimer's disease. I identified with them as a mother and it hurt. These were clearly my issues arising in the counter-transference. I was able to share this with a friend; she didn't offer any answers because there weren't any, but it brought healing to me and enabled me to continue to do my job. We all need this. It is essential for our well-being. Reflective practice can be an important means for this to occur. Although talking it through with a friend may not be regarded as truly

reflective practice, in this instance I would disagree. I was exploring practice in a confidential setting, and she was certainly able and willing to challenge my views when appropriate.

There is a concern that reflective practice cannot become a form of therapy for the practitioner. I agree, but the dividing line is I think very thin. In some instances this has resulted in practitioners, in their eagerness to guard against this, almost fleeing from anything which touches the emotional aspects of practice. If you consider again the 'iceberg of professional practice' proposed by Fish and Coles (1998, pp. 305-306), this picture emphasises the role of emotions. Winter (1999 p.188) comments how the emphasis within reflection on practice suggested by Schon (1983) appears to him to be largely cognitive based, whereas the reflection proposed by Boud et al. (1985) encompasses all aspects including the affective element quite explicitly. There does appear to be a move away from the purely cognitive bias in some of Schon's later writings, in particular in *The Reflective Turn* (1991). In this collection of works, which Schon edits, a variety of settings and modes of reflective practice are presented.

Considering the development seen in Schon's work, and taking into account the criticisms of both Eraut (1995) and Winter (1999), his work has to be viewed from a developmental perspective. You could argue that we are privy to this process, and that it is a form of reflection. When Schon introduced the idea of reflective practice, it was in a climate where the technical-rational view of professionalism was highly prominent. Therefore, it is not surprising that in his original works so much time is spent refuting this to introduce the idea of professional artistry. Indeed, if that foundation had not been established it would not have been possible to develop the concept of reflective practice. It is notable that it is Schon's work, not Boud's, which is seen as seminal and most often cited as the turning point within our understanding of professional practice. I would suggest this is because he deals explicitly with the foundational issues. I doubt whether Boud's work alone would have had the same impact because he does not address professional artistry versus technical-rationalism in the same depth. I also suspect that it would not have had the same credibility in the scientific community at that time. Given this climate, and the paradigm shift that was being advocated in the view and understanding of professional practice, it is

unsurprising that a cognitive based view of reflective practice would develop first. It would initially be more readily understood, and once that understanding was fostered, the concept could then be expanded. From that basis, reflective practice was able to evolve and encompass all aspects seen in the picture of professional practice, including the affective or emotional aspects, proposed by Fish and Coles (1998).

A particular problem in medicine, which contributes to the avoidance of the emotional aspects, is the denigration of anything viewed as subjective and therefore non-scientific:

> The difficulty is that doctors have been taught to distrust their personal stories in the name of big science. Such science can be a normalizing truth that tends to disqualify, limit, deny or contain other potential stories.
> (Linden West 2001 quoting White and Epston 1990, p.208)

My view is that when emotional aspects arise within practice, and even when they link into our private selves and histories, we should acknowledge and address them within reflective practice. If, however, it becomes evident they are highlighting a problem located primarily within ourselves, rather than within practice or its effect on us, then this should be addressed within the context of personal therapy (Bolton 2001 p.151). Quite clearly this will not always be clear cut and may become evident over time. It requires flexibility, sensitivity and tolerance of uncertainty. If, however, reflective practice occurs in a safe context of confidentiality, trust and respect then addressing this distinction will not be problematic.

This leads on to an important arena for reflective practice that is just beginning to be recognised within medicine. This is the mentoring relationship (Grainger 2002). It has been set up within the South West Division of the Royal College of Psychiatrists for newly appointed consultants and arose from an awareness and acknowledgement of the increasing disillusionment and morbidity amongst senior doctors. Within psychiatry there is a high percentage of vacant consultant posts with an increasing desire by established consultants to take early retirement, the deciding factor usually being financial considerations. I have been fortunate to be part of this scheme since

taking up my substantive post in 2000. I can personally endorse its benefits. There are ground rules to protect both parties. Obviously it is dependent on personal factors whether individual relationships can be fostered. The setting up of a mentoring relationship is therefore contingent upon both parties feeling comfortable with it. Within that framework there is great variation and flexibility. It is entirely confidential and divorced from any regulatory features. These conditions open the way for reflective practice that can cover all aspects of professional life. It is also, I think, a possible arena for those very aspects I discussed earlier, where the emotional aspects of practice are so pertinent.

Mentoring is relatively new within medicine, a similar concept being critical friendships. Golby and Appleby (1995) describe the operation of such a relationship within an educational setting. The important contribution their work makes is the reflection on this relationship itself, including the benefits and pitfalls. The important factor again to recognise is that the process must be enabling not prescriptive, and each of these relationships will be unique. Clinical supervision within nursing is another similar concept, and Dewing and Woodrow (2001) describe the operation of this. However, my understanding of this from discussions with nursing colleagues is that it is based within a formal hierarchal situation, and seen very much within a superior/subordinate role relationship. This was emphasised in a Trust-wide workshop on reflective practice presented by one of our Nurse Therapists. I have also observed this in my own observations of its operation in practical situations, in one instance 'critical friendships' were instigated following a critical incident as a means to address issues. It does appear to be clearly linked to appraisal and the choice of the wording clinical supervision further emphasises this. From my observations this is the process I regularly employ with trainee doctors with whom I have a supervisory role.

The mentoring relationship is usually largely verbal. Although I would advocate the development of skills in writing and their use within reflective practice, I certainly would not undervalue the oral tradition, especially in medicine where it is so clearly established. There is a place for formal reflective practice groups to be established. Amies and Weir (2001) describe the operation of one of these groups within social work. The value of more informal opportunities should not be underrated. These

frequently took place within the context of the doctor's mess where invaluable spontaneous discussions took place. Unfortunately in our consumer-orientated culture, which demands that every second of our working life is accounted for, including lunch breaks, this is seen as a luxury certainly to be dispensed with.

CONCLUSIONS

The review of reflection on practice has demonstrated to me its centrality to professional practice, the importance of demonstrating this to the profession at large and the public, and the fundamental importance for it to be rooted in a view of professional practice as artistry. The conditions for reflective practice to be fostered require both a safe context and flexibility. Most of all it requires practitioners who are willing to engage in it, who will tolerate uncertainty and who are able to accept critical enquiry into their practice.

Following on from this discussion, I would suggest that the artistic/holistic paradigm is a suitable vehicle for continuing professional development. This approach encourages reflection on all levels of practice, and this practice is then confronted within the critical appraisal. The artistic/holistic paradigm promotes exploration of the deeper layers of the iceberg of practice. This paradigm recognises explicitly and provides the means to explore the artistry within professional practice. All of these facets are foundational to the professional judgements we make within practice. The refinement of our professional judgements, I would argue, is the core of continuing professional development.

In addition, the size of the work is flexible and can be small or large scale depending on the needs of the practitioner. Certainly, this format could be used in a journal or learning portfolio mode and is therefore suitable for everyday clinical practice, as well as larger scale undertakings such as this thesis. Indeed, this type of journal could appropriately be incorporated into peer review groups to encourage further critique of the work.

Reflection and critical appraisal of practice are essential for its development but not sufficient. The practice itself needs to change or develop as a result of this. True

continuing professional development means an ongoing reconstruction of our practice, both individually and corporately. Our practice will be reconstructed as we incorporate the insights we gain through the reflection and appraisal of what we are currently doing. Indeed, if these processes do not affect our practice then I would question the purpose of engaging in such processes.

As a result of this study, my own practice has been reconstructed both at a clinical level and at a research level. I outline these insights in detail in the final chapter. These insights are now incorporated into my everyday practice. Practitioners, both within the clinical team and outside, have said how their clinical and research practice has changed from the discussion and presentation of this work. Their practice has been reconstructed or developed. This is professional development, which is an ongoing process and the central feature is a critical reconstruction of practice through dialogue. This work has implications for the whole profession and will be discussed in chapter nine.

CHAPTER 9: FINAL REFLECTIONS

INTRODUCTION

In this chapter I draw together the various strands within this study in an attempt to bring a unity to this work. I also consider some of the potential implications of this work and the similar studies which might arise in the future. I do not attempt to provide a definitive answer but rather to stimulate further discussion and debate. Indeed, if this occurs then the work has been worthwhile.

INSIGHTS GAINED BY THE PRACTITIONER

I call these insights rather than conclusions, because insights can continue to develop and do not convey the finality of conclusions. Insights are just one stepping-stone giving the person standing on it the potential to move to the next stepping-stone, and therefore continue moving forward. This is how I see this study for myself, and I hope my readers will have a similar experience.

The Personhood of the Practitioner

As I reflect on this work, one of the most important outcomes, as a practitioner, is allowing me to be a whole person within my practice. Repeatedly as I have reflected on the episodes of practice and related this to the wider issues, I have been struck how the practitioner and the person are fused together. In fact, recognising this and the foundational aspects of our personhood adds, I believe, strength to our practice. In medicine over recent years we seem to have spent much energy obliterating the individual clinician and standardising practice. Certainly in the prevailing 'scientific view' of research, the individuality of the researcher is a nuisance factor to be minimised as far as possible. Within clinical practice there is a push for guidelines and protocols to be established with an underlying assumption that the identity of the 'technician' carrying them out has no relevance, provided they have the prerequisite competencies. Yet Elsie's case highlighted the central importance of each of the individuals involved in her journey of healing. Moreover, what they brought to that process was their personhood, both individually and collectively as a team. The

technical intervention, the antidepressant, had a minor role within that journey. This issue of the healing process was a topic I examined in depth within chapter three. The over-riding conclusion was that this process primarily revolved around relationships. As I considered other instances within my own practice, I began to realise that this is true.

Although technical interventions, such as medication, are used, the important factor in the success or otherwise of an intervention will often depend on the trust developed with the practitioner. This is the reason patients can become distraught when they have to see another equally competent practitioner. The personal relationship is important. In my clinical practice, therefore, I am clearly bringing myself as a person, and I, the person, am a valuable asset. Equally, I need to be aware of this so that I can also critically appraise whether aspects of me are a help or a hindrance to my role as a practitioner. This relates to those deeper levels of the 'iceberg of practice' (Fish and Coles 1998, pp.305-306). Our beliefs and value systems are embedded in our personhood.

Regarding my research practice, I have begun to see that I am valuable in this context as well. To explore my professional practice, I needed to look at it from a personal perspective. There was a need for me to tune in to my own personal intuitions and ways of perceiving things. These are the very aspects likely to be skimmed over, if acknowledged at all in the current climate. Yet out of this came a deeper and richer comprehension of professional practice. Acknowledging where I came from and why I viewed research so negatively at the outset of this work enabled me then to choose to move beyond this. My choice to explore research practice came from my deeply held convictions that there was more to research than randomised controlled trials, and a desire to capture the artistry or beauty inherent in professional practice.

My expertise as a professional is not just based on technical skills but also includes the harnessing and fine-tuning of my own unique and personal qualities. I can now appreciate my personhood rather than see it as a nuisance factor that should be minimised.

The Moral Basis of Professional Practice

Although it may sound obvious that medicine is a moral endeavour because of the ethical issues that arise within practice, there is a fundamental sense in which the moral basis of professional practice has become eroded with our technical-rational view and consumer-based society. Without fully appreciating it, we have moved to expect a technical intervention to be available for a health need and for this to be available on demand, in the same way a supermarket operates. The moral obligation is reduced to providing the intervention on demand, which emanates from a consumerist viewpoint. This is far from the moral basis of professional practice as characterised by phronesis, or practical wisdom. Here, judgement is exercised as to the moral good of the individual in question and the means of attaining this. This judgement continues to be exercised throughout the process and is individualised, a far cry from a standardised commodity to suit all. I have come to appreciate the centrality of this concept in medicine and indeed this is the means for practitioners to truly meet an individual's needs. Therefore, I devoted a chapter to the exploration of professional practice.

Coming to appreciate this moral basis of my practice, and therefore the importance of the professional judgements I make, has released me from the tyranny of evidence-based medicine. I am no longer frustrated when it's difficult to find the right button to push, or when the patient won't fit into the expected box and respond in the expected manner. Uncertainty and the unexpected is an opportunity, not a nuisance. I can 'enjoy' patients as individuals, and together we can continue to seek the right way forward for them.

Artistry and Its Celebration

As I draw this work to a close, artistry is perhaps the most significant insight for me personally. Coming to a place where I can both acknowledge and express the artistry within my practice has a liberating effect. Even if no-one else agrees with me, I know it has enriched my personal practice. Of course I would hope it influences other practitioners and fosters this insight within their own practice. I was aware of something of the artistry within practice prior to this study, but I could not put it into

words or explore it further. Using the artistic/holistic paradigm has enabled this concept to crystallise, and provided the tools to use to explore it.

To celebrate something of worth is quite a novel concept in the current climate in which we practice. I would emphasise that this does not preclude appraising those aspects which require change, but we have forgotten to appreciate the good things. It is through this appreciation, or celebration, of the artistry that we can inspire ourselves, and fellow practitioners, to continue and develop it further. From this work, for instance, I now value and appreciate the pictures I build up concerning cases when I mull them over. I also pay more attention to the fleeting thoughts other members of the team mention, and seek to develop them further in discussion. I also have more confidence in my own intuitions, which I will now listen to and then decide to verify them or not.

Research practice is no longer a dry endeavour to be endured but a worthwhile and enriching experience for the practitioner. I found this mirrored clinical practice and involved artistry. All aspects of professional life have inherent artistry and that includes the research of our professional practice. The portrait of the research practice and the critical appreciation arising from it enabled me to value it. This has shown to me that this type of research has furthered my own professional development and has this potential for fellow practitioners. I discuss continuing professional development in more depth later.

Evidence-based medicine

I have frequently referred to evidence-based medicine throughout the thesis and I feel it is appropriate for me to draw together some of my specific thoughts about it as I draw this work to a conclusion. Considering the influence this has on all healthcare professionals' everyday practice I am not surprised that it has occupied a significant part of my own deliberations even though I did not set out to specifically explore this issue. It is also notable that when people encounter this thesis the issues around evidence-based medicine often become the focus of discussion, resulting in other practitioners expressing a strong desire to defend this concept. Again I would suggest this demonstrates the power and influence of this concept within healthcare practice.

The insights I have gained about evidence-based medicine have crystallised from my own experience within practice, discussion with other colleagues both within a clinical and research setting and from the literature within medical circles that I have accessed. I would emphasise these are personal insights of one practising psychiatrist and because I practise within a medical not nursing culture I have concentrated on the literature within the medical world to illustrate the influences on medical practitioners. It does appear to me there is a broader acceptance of different types of evidence within nursing and allied healthcare professions, including qualitative research, and the term evidence-based practice is used (Jones and Higgs 2000), rather than evidence-based medicine. However, my experience is that this does not impact medical practitioners at the current time. Therefore, this is not an exhaustive review or analysis but rather an insight into a clinician's perspective.

In my opinion, although my views may differ from the views within academic circles for instance, they are valid. They illustrate how the concept of evidence-based medicine is impacting clinicians at the 'coal face'; and indeed if the fundamental intention is to improve everyday practice this understanding is crucial. Reilly (2004) and Straus and Jones (2004) in a special edition of the British Medical Journal reviewing evidence-based medicine, ask the important question how do we know if evidence-based medicine is changing practice? Central to answering this question is to know the views and attitudes of the clinicians whose practice is intended to be modified.

As a practising clinician I completely agree with the principle that our practice should be based on the best available evidence and it would be hard to disagree with that sentiment as Reilly (2004) argues. From my experience when medical practitioners talk of evidence-based medicine they equate 'real' evidence with quantitative research, preferably randomised controlled trials. In the recent review in the British Medical Journal this is underlined:

> Students have to grasp two essential principles of EBM: its empirical approach to optimal clinical decisions (regardless of pathophysiology, does the bottom line of the balance sheet

> show gain or loss?); and its quantitative expression (how big is that gain or loss?).
> (Del Mar et al 2004, p.989)

This sums up my experience and discussions with other colleagues. The emphasis on quantitative reasoning is further accentuated in the origins of evidence-based medicine (Guyatt et al 2004) and in its teaching methods (Del Mar et al 2004; Sackett et al 2004).

My concerns however, are twofold. Firstly, quantitative reasoning is only one form of evidence and in my experience this leads to many other sources of evidence-based medicine being discounted in everyday practice. Secondly, evidence-based medicine presents an oversimplified view of clinical decision-making.

As I have emphasised throughout this thesis my opinion is that professionals must not lose sight of the moral basis of their practice, at the centre of which is practical wisdom. There is beginning to be recognition of the wider components in medical decision-making:

> Exponents increasingly emphasise the limitations of using evidence alone to make decisions, and the importance of the values and preference judgements that are implicit in every clinical management decision. They now see clinical expertise as the ability to integrate research evidence and patients' circumstances and preferences to help patients arrive at optimal decisions.
> (Guyatt et al 2004, p.990)

However, I still feel these components are seen as a 'bolt on' to the main component of quantitative reasoning at the centre of the evidence-based medicine movement (Schon and Stanley 2003). This is further demonstrated to me by Downie and Macnaughton (2000) when they discuss adding 'humane judgement' (p.103) to technical interventions. It appears to me that the technical intervention retains primacy of place in all of these discussions. My personal view from reflection on my

own practice is that this is an unbalanced view of practice and we need to return to a holistic view, which would include the artistry within professional practice. Indeed, I believe this artistry fosters and enables the practical wisdom central to professional practice. This would entail a revision of our belief systems and is therefore not a simple process but requires debate within the community of practitioners. There are signs this is beginning to occur in the field of surgery as evidenced in the work of de Cossart and Fish (2005).

If we were to collectively accept the holistic view of practice I am suggesting this would I believe, present more challenges than the present evidence-based medicine model. For instance artistry within practice would need to be evaluated and promoted alongside the technical aspects of medicine. I have argued in this work that the proposed artistic/holistic paradigm is an ideal means to do this but perhaps a daunting prospect when it brings us face to face with some of the dilemmas endemic in everyday practice that are not amenable to simple solutions.

Therefore in undertaking this reflective inquiry I have come to understand my own disquiet with the evidence-based medicine movement as I have experienced it in my everyday practice. I do not feel it is sufficient just to modify the concept but rather the foundation on which the concept has arisen needs to be reappraised.

RESEARCH AIMS REVISITED

At the conclusion of the work, it is timely to revisit the research aim and to assess how far it has been realised. My aim was:

> To determine how research can be meaningful and relevant to practitioners.

Research has a much wider meaning than a randomised controlled trial, or even an experimental study. This work is a careful investigation of an episode of clinical practice and a diligent search for a research methodology that is appropriate to the exploration and development of that practice.

I have come to this work as a practising clinician not as an academic or practitioner whose practice is primarily research. My experience, and therefore conclusion, from this work is that using the artistic/holistic paradigm is apt and appropriate to the nature of the practice being investigated. This approach fostered the exploration of my practice, including the artistry within it, and led to the development of that practice. The work relates to everyday practice, or as Schon (1983) would call it, the research is located in the 'swampy lowlands', and it is directly relevant to that real life practice.

Reflection as Research

This type of research has reflection at its centre. The reflective process is itself the means of research. It encompasses both reflection in action, which is primarily seen in the research practice, and reflection on action, which is predominantly but not exclusively evident in the consideration of the episode of clinical practice.

This work is an example of reflective practice but there are many different forms possible, an issue I highlighted in chapter eight. Reflective practice is not synonyms with artistic practice, although in this work the two are closely intertwined. For example a critical incident review is a form of reflective practice. Following the incident in question an analysis takes place during which the practitioners involved are asked to reflect on what happened, their reasoning at the time for their actions and to consider whether they would now choose a different course of action. This is clearly reflective practice but not artistry. Its use is not to extend the practitioner's understanding of practice but to put systems right for another time!

Certainly reflective practice can be an artistic process as in the case of this work, both in the exploration of my research and clinical practice. I specifically sought to explore the artistry inherent in my clinical practice and in so doing discovered it also within my research practice. I chose to use the artistic/holistic paradigm because I felt it was well suited to do this. The artistic/holistic paradigm employs reflection within a framework of artistic processes to specifically explore artistry inherent within professional practice. This is a specialised form of reflective practice.

The reflective process is flexible and not tied to a model. Rather, it is a reflective inquiry. This is evident in the critical appreciation of the portrait of clinical practice, and discussed in chapter seven, as I considered the process of producing a critical appreciation. I have returned to this concept again in the conclusions because it is fundamental to appreciating this work. The reflective process, I found, must be allowed to emerge from the practice being considered and to encompass all types of reflection. As Fish (1998 p.102) states in particular reference to critical appreciations, 'an activity or an object is responded to critically in order to understand it by any and as many means as possible'. A critical appreciation is a reflective inquiry conducted by a connoisseur into the subject being critiqued.

There are many forms and levels of reflection possible. In fact, this type of reflection is far richer and deeper than the recognised models, which I argued in chapter eight often return to a technical-rational stance. Reflection includes consideration of the artistic processes within practice and the discovery of the means to convey this, often using figurative language. The reworking of the portrait requires much reflection both on the emerging portrait and the original practice. In the critical appreciation, the reflective process is the inquiry and triggers further investigations if appropriate to promote reflection. Allowing our creative abilities and imagination to become involved in the reflective process can bring insights which would otherwise remain hidden. Just because these insights cannot be gleaned from 'objective scientific' research does not mean that they are irrelevant to practice. In fact, they are probably more fundamental and relevant if you consider the 'iceberg of practice' (Fish and Coles 1998, pp. 305-306). Greenhalgh and Hurwitz (1998) argue that narratives, or stories, are fundamental to the practice of medicine. They point out that in telling a story:

> …both you the narrator and we the listeners would be compelled to reflect on it in order to gain a greater understanding of what had gone on.
> (Greenhalgh and Hurwitz 1998, p.4)

The importance of generating and sharing these stories or reflective inquiries must not be underestimated both for the development of our individual practice and also

that of our profession. In addition, the narrative means which promotes reflection moves away from the disembodied and sanitised reality increasingly prevalent in health care today. The reflective inquiry is fundamental to an individual needs-led service, which was my original starting point.

I have concluded that reflection is a research activity particularly suited to the needs of practitioners, whether their practice is primarily clinical or research. The reflective inquiry enables the practitioner, and perhaps more importantly groups of practitioners, to examine their judgements. Carr states:

> It is 'right' action because it is *reasoned* action that can be defended discursively in argument and justified as morally appropriate to the particular circumstances in which it was taken.
> (Carr 1995, p.71, italics in original)

The process of reflection provides the means for the reasoned action to be discussed and evaluated. Carr talks of this action being 'defended discursively', which highlights the central role of dialogue in this process. Practitioners' reflective inquiry cannot be conducted in isolation – there needs to be a dialogue. This can of course take many forms. The dialogue may be directly in discussion with other colleagues. In this study I engaged in dialogue with colleagues involved in Elsie's care and with my supervisors about the research practice. A dialogue can also occur in other ways, for instance with the literature, and that was evident in this study.

The role of the reflective inquiry and the inherent dialogue are fundamental to professional development and a point I will return to again in this concluding chapter.

Autobiographical Reflections

I discussed the place of autobiographical work in chapter six during the consideration of the creation of the portrait. However, there are a few further points I would raise in the conclusion to this study.

Throughout this work, my own presence as a practitioner researcher is strongly in evidence. I am aware that this is quite unusual – even unexpected – in a dissertation. Clearly, more 'personal' research has come to be accepted within the social sciences paradigms but this study takes even that a step further. There is a danger that on first sight it could be seen as self-indulgent research. I would contend that the work presented here goes beyond a personal journal endeavour. The autobiographical reflections are part of the research process. Fish and Coles (1998, 203-221) argue this point in their appreciation of the autobiographical case studies of their contributors. One of the fundamental issues is that you cannot separate the practitioner as a person from their work. The two are intimately and irrevocably bound. Our belief and value systems, which become the bedrock on which our practice is built, are an integral part of us the professionals, and are the result of our life experiences. Therefore, in researching practice, it is appropriate to consider and reflect on those life experiences that have shaped us. This interplay of the person of the practitioner with their practice is one of the issues which I feel has been underlined for me as I proceeded with this research.

Radovich and Higgs (2001) use the autobiographical mode to inquire into the development of Sue Radovich's clinical practice. Alongside the description of the life events, they specifically employ headings to indicate reflections arising from this, in a similar fashion to the mode I adopted in the portrait of practice in chapter two. Sikes and Goodson (2003) both present their life histories and reflections arising from these in relation to their research practice, and its development to its current form. Both of these accounts illustrate the value of autobiographical reflection in researching the practitioner's practice. Certainly, these arguments establish that autobiographical reflection enriches and develops the individual practitioner's practice, and will be an integral part of the professional's ongoing development.

THE DEVELOPMENT OF THE PROFESSION

Professional practice can only remain healthy if both individual practitioners and the profession as a whole continuously develop. I have discussed at length the individual practitioners' development but now I focus on the community of professionals.

There are three spheres within which a professional operates. Firstly, we are individual practitioners. Secondly, we are members of a community of professionals. the medical profession. As a collective group we debate and reconstruct our practice. This occurs through informal means between colleagues and more formal discussions, for instance within the Royal Colleges. No practitioner can function without regard for the community within which they are embedded. Indeed, when individual practitioners disregard this, disciplinary procedures may result because their individual practice becomes poor. Thirdly, we function and contribute to the historical basis of our profession, its tradition. Professionals practise within a tradition as Carr succinctly describes:

> To practise is thus never a matter of individuals accepting and implementing some rational account of what the 'aims' of their practice should be. It is always a matter of being initiated into the knowledge, understandings and beliefs bequeathed by that tradition through which the practice has been conveyed to us in its present shape.
>
> (Carr 1995, p.68)

The tradition of a profession encompasses far more than just knowledge. It includes understandings and beliefs. Professional practice is a moral enterprise and is a socially embedded human activity that has developed over time (Carr 1995). Our collective professional history is as important as the present. The current 'ethos' of the profession has evolved and grown from the successive deliberations and debates of our professional predecessors. Our current deliberations and debates contribute to that ongoing evolution. Just as individual practice needs to be in a continual cycle of reconstruction so does our collective practice. The reconstruction of individual and collective practice is intricately intertwined.

The aims of our practice are not easily elucidated in each case; rather they remain contestable and debatable. Frequently, there is not one obviously right answer. This is why there must be an ongoing debate within a profession, in this instance the medical profession, to reach an agreed consensus on the 'morally worthwhile' good that we seek. This can be between professionals at a local level in individual cases or on

more general principles within a larger section of the profession, such as the Royal Colleges. Carr, drawing on the work of Aristotle, writes:

> Moreover, in deliberative reasoning, it is always conceded that there may be more than one ethical principle that can supply the content to a major premise and that there is no formula for methodically determining which one should be invoked in a particular practical situation. It is for this reason that Aristotle insists that collective deliberation by many is always preferable to the isolated deliberation of the individual.
> (Carr 1995, p.71)

Because of the deliberative reasoning, or professional judgement, that is central to our practice, we must engage in collective deliberation. This is the means to ongoing development and meaningful regulation of our profession. An ethnographic study by Gabbay and le May (2004) looking at the implementation of evidence within primary care emphasises the important role collective debate plays within this process. In regards to regulation, this needs to be within a peer-based system because of the complexities of our practice. This was alluded to by O'Neill (2002) in the Reith Lectures, but the collective deliberation needs to be open to public scrutiny.

In conclusion, for the ongoing development of the profession, we need to engage in the tradition of 'practical philosophy' proposed by Aristotle:

> It is the 'science' which seeks to raise the practical knowledge embedded in tradition to the level of reflective awareness and, through critical argument, to correct and transcend the limitations of what within this tradition has hitherto been thought, said and done.
> (Carr 1995, p.69)

I would argue that this is indeed an important but perhaps neglected area of science which needs to be revived and brought into mainstream medical practice. There will be opposition to this because it certainly is not within a technical-rational view, and is complex and contestable just like everyday practice. The artistic/holistic paradigm is

an excellent means within practical philosophy. My only concern would be that the name will deter medical practitioners from exploring the possibilities it might offer them to research their practice.

The Contribution of this Research to the Profession's Development

Deliberation with fellow professionals has occurred in several ways within this research and involved different areas of practice. The results of these deliberations contribute to the traditions of medicine and in particular to psychiatry.

There was direct discussion with colleagues, which included the practitioners involved in Elsie's care and other colleagues when presenting or discussing the research. There was also a deliberation within the wider community through the use of literature, a theme I addressed in chapter seven. These deliberations within the community of practitioners, including medical and research practitioners, have an impact on the practice of psychiatry and medical research, and thereby influence the traditions within which we practise.

The implications of this deliberation affect several areas of practice: clinical practice with individual patients, wider aspects of professional practice in clinical practice, research practice, and educational practice. This reconstruction of practice has been the theme running through this thesis and each area has been addressed. I will now reiterate the major reconstructions covered as I draw this work to a close. These reconstructions are offered to the medical profession for further deliberation and as a contribution to our evolving tradition of practice.

1) Artistry is inherent in professional practice and needs to be both recognised and developed.
2) Theories-in-use fundamentally influence our practice and must be made explicit for practice to develop.
3) Healing is not the same as curing. The medical profession needs to reconsider its role and functioning, moving away from an exclusively disease-based perspective to a person-centred perspective.

4) Professional practice is a moral-based activity and cannot be reduced to a purely technical intervention. It is through the exercise of practical wisdom that the needs of the individual are recognised and addressed.
5) The relationship of the profession with society has to be explored and the means of conveying the complexities of professional practice and accountability sought.
6) Research practice is multi-faceted and can be tailored to the needs of the researcher and the topic being explored. The proposed artistic/holistic paradigm is offered as one facet particularly suited for insider practitioner research, by fostering the exploration of artistry while being inclusive of all other paradigms.
7) Professional development is not the amassing of more knowledge but the pursuit of a practical philosophy to develop practical wisdom. This research has been an example of this.

CHAPTER 10: PERSONAL REFLECTIONS AT THE END OF THE JOURNEY

INTRODUCTION

I have throughout this work included many reflections, some of which have been quite personal to me the researcher. This is not surprising because this is a reflective inquiry into my own practice. I therefore feel as the journey comes to a close it is appropriate to draw out and consider in depth some of the dilemmas and issues I faced as this work developed.

Firstly, I will focus on the challenges in undertaking a reflective inquiry of one's own practice. Secondly, I will address the dual role and its implications of the researcher-practitioner. Thirdly, I will consider the experience of the research journey I undertook and fourthly, I will discuss the issues about the value of this work.

A REFLECTIVE INQUIRY

This piece of research is primarily a reflective inquiry of my own practice and as I have emphasised includes my research as well as my clinical practice. Therefore it has been a developmental piece of work, or journey. The end or destination could not be known until it was reached and certainly the finished piece is very different to what I imagined it would be when I embarked on this. I have needed to accept this uncertainty and constant revision of the work as it evolved. That did bring challenges and pressures to me on several levels.

There is a possibility that the work will be viewed as too subjective and personal to the researcher to be of use to other practitioners. Partly this arises because medical practitioners are not accustomed to this type of work and has resulted from the pressure perceived by my colleagues to justify any 'research' as objective and detached. This does mean of course that my work may not be accepted.

The reflections are very personal to me and this has meant allowing myself to become vulnerable and exposed professionally. There is a huge difference between reflecting on your practice privately, which can and does include discussion with trusted colleagues, and placing these reflections in the public arena. Anyone then has access to your thoughts and can criticise you personally. Yes, I agree we all need to critically appraise our practice and this cannot be done in isolation from the community of practitioners, a point I laboured in the thesis, but this is quite distinct from being open to all forms of criticism over which you will have little or no control. To feel unfairly judged concerning a piece of work from which you feel some detachment is difficult but this is multiplied when the work is personal to you.

I was acutely aware that the research I undertook might be misunderstood especially as the work developed. During the transfer process from MPhil to PhD the examiners emphasised that I could develop the work along a more traditional qualitative inquiry and choose not to explore the proposed artistic/holistic paradigm by Fish (1998). Indeed that would have been the safer and easier option but I knew I would not have remained true to myself and the desire to explore my own practice. I would have felt that I had settled for second best, or stopped half way up the mountain and never seen the view from the summit.

One area where misunderstanding of my work can arise is in the portrait of practice. In considering the clinical episode of practice I was not primarily there to describe the other practitioners' practice but to use my observations and discussions of the episode of care to draw out my vision of this episode of care and reflections as a practitioner. This is one of the main reasons why this work is a portrait as opposed to an ethnographic presentation. The work is very subjective and in a sense personal to me. I am aware this can cause difficulties in appreciating this work if these differences are not clearly understood. The developmental nature of this research can compound this because when I began the research I was approaching it from a social constructionist viewpoint and indeed if the work had not developed the final piece would have appropriately been in an ethnographic format. This is why the portrait of practice can appear

on first reflection to be inadequate because it does not include quotes from the participants to justify each of the insights presented. Instead when quotes are used, their purpose within the portrait is to serve the intentions of the artist to convey to their audience the experience of the piece of practice not to justify the validity of their interpretation.

Looking back if I were to commence on this work now, knowing what I have learnt from completing this research I would approach it quite differently. I would be clear that I was researching my own practice and might choose an episode of practice where I was actively involved as a practitioner. This would of course bring other dilemmas that would need to be considered. However, this would help to clearly demarcate this work from similar but different genres. Nevertheless, I could not have reached this place without first undertaking the journey. I had to reflect on my research practice to realise where I was actually seeking to go in research.

Another challenge has been the need for a very personal involvement and investment in this work. By this I mean there was an obligation to access within myself the deepest layers of my 'iceberg of practice', my beliefs and value systems. I could not take things at face value anymore and it was hard work, it meant a lot of thinking time and challenging discussions. In this sense the research impacted my practice from the outset and continues to do so. I find myself questioning why I'm thinking in a certain way about an issue, or why I chose a certain course of action I am not satisfied to simply say it seemed right at the time. I would suggest that has made me a more 'mindful' practitioner who is constantly reappraising her own practice.

When I speak of 'my practice' I do not just mean my clinical practice but also my research practice. In chapter one I spent time explaining my background and the beliefs I had developed about research many of which I had come to realise were shared by my colleagues. I would again emphasise by sharing these does not mean that these are justified or universal, they are however valid because this is a reflective inquiry of my practice. These beliefs are also relevant because they are not unique to me but are shared by colleagues within clinical practice

and certainly their development has occurred in the context of a community of practitioners with whom I have trained and worked. Therefore even if you vehemently contest these beliefs, for instance regarding evidence-based medicine, you need to question why some practitioners hold them.

I have come to appreciate that research does have a wider definition and can be very relevant for the practising clinician. As a result of completing this work I feel reflective inquiry is a valid research activity and its worth has not been fully recognised within medical circles. It can be a useful tool both at an undergraduate and postgraduate level, in other words an appropriate medium for continuing professional development. This is certainly a research activity that I will continue to pursue and to my surprise, given my earlier experiences, I have found both enjoyable and worthwhile. Considering my original views that research was something to be endured because it was expected of a trainee this is a radical change in my belief system. I would hope that sharing my journey might cause colleagues who feel similarly to how I did when I embarked on this journey to consider undertaking a reflective inquiry of their own.

There is no doubt in my mind that a reflective inquiry suits the needs of the practitioner because the inquiry is directed from practice, in other words the issues or dilemmas arising within it. A reflective inquiry is flexible and responsive, it is not prescriptive. This was my experience as I undertook the work and for me this aspect counterbalanced the anxieties arising from the inherent uncertainties evoked. Uncertainty, I feel, is fundamental to professional practice and can be acknowledged within a reflective inquiry. In fact I would suggest the uncertainty involved in a reflective inquiry mirrors the uncertainty within professional practice and maybe why, this form of inquiry is so well suited to the exploration of practice.

One area of my practice that I was seeking to explore was the artistry. Undertaking a reflective inquiry allowed me the flexibility to explore different methodologies until I found one, the artistic/holistic paradigm, which met my requirements. Another practitioner exploring their practice may wish to specifically investigate a different aspect of their practice and consequently

choose a different methodology after considering those available. The work I have presented here is not prescriptive rather it is an example to inspire fellow practitioners.

In concluding my thoughts about a reflective inquiry I would finish by emphasising that this mode of research is certainly not an easy option but in my opinion more demanding because of its personal nature. The researcher cannot be detached; you have to be prepared to question yourself and to be challenged by others, in other words you have to be prepared to critically appraise your practice.

RESEARCHER-PRACTITIONER ROLE

Throughout this piece of work there was a tension between the two roles of researcher and practitioner. I have suggested that this was insider practitioner research. There is no doubt in my mind that in regards to my research practices this is entirely justified: I was the research practitioner researching my own research practice. In regards to the clinical practice the situation is less clear cut, partly due again to the developmental nature of this work and this is an area I propose to reflect on further.

At the outset I had the role of a researcher who was observing the other practitioners' practice to consider a needs analysis of the patients' needs. I was 'outside' and not considering my own practice and professional judgements. You could argue that I was an insider because I am an Old Age Psychiatrist, so this was my area of practice, and I was known and accepted as a practitioner by the team. I was also an insider because the patients knew I was a doctor and this I am sure influenced their perceptions of me as 'one of the team'.

However, the focus of the work evolved to the exploration of my view of practice and the professional judgements this entailed. The practitioner, my professional practice, and I became the centre of the inquiry. Yet at the same time I was not an active clinical member in the episode of care for Elsie. I was both inside and outside in one sense.

This did have some advantages for me. Not being active clinically within the case allowed me the luxury of having time to reflect on all that was happening free from any pressures to sort out or resolve issues. I could concentrate on my professional judgements and the reasoning behind them. Equally you could argue that is not representative of clinical practice because as I said, time to think is a luxury in everyday practice. I would argue however, this was a tool to enable that reasoning which would be occurring anyway, albeit unacknowledged, to be revealed and therefore appraised.

The discussions and reflections with members of the team involved in the case were an important component. In everyday clinical practice I would not be forming clinical judgements in isolation, we work as a multidisciplinary team therefore it is appropriate in exploring my own practice to mirror the everyday practice. In this aspect I am an insider but I am not 'active' in the team decisions concerning the management of Elsie's case. I particularly qualify 'active' because although I do not contribute in the normal way to the management decisions the discussions I have with individual members will potentially alter their own views and judgements they make. Therefore I remain in this position of also being outside the practice.

As I consider this research at the end this was perhaps one of the most challenging aspects. I was never a complete insider but neither was I a complete outsider. I had to maintain that position and to put aside the very role I was being trained for, to provide medical leadership to the multidisciplinary team. There were times when undoubtedly the team did look to me for that leadership and it was important not to leave them feeling unsupported but equally to signpost them back to the appropriate member of the team for the direction they sought. This was particularly evident in Elsie's case when her CPN was acknowledging the symbolic importance of amitriptylline to Elsie but it was not yet being 'heard' by the Senior Registrar. He did hear this but just later on. In this situation I needed to listen and affirm the CPN's thinking without imposing my own, which could have undermined the Senior Registrar's working relationship with her.

In conclusion I felt this work was indeed insider practitioner research albeit unusual and raising some complex issues, which I have outlined above. There is no doubt for me personally that I have researched my own practice on several levels but perhaps it is more appropriate to regard this work as insider/outsider practitioner research for the reasons I have outlined.

THE RESEARCH JOURNEY

During my journey on this research there were many dilemmas I had to face, some predictable but many unexpected, right up to the final revision of the thesis. I would like to take the opportunity now to reflect on these and their impact on me, the practitioner.

This piece of work certainly evolved into a bigger project than I first envisaged and became, in one sense, a time consuming passion. Once I started to reflect, initially on my research practice, the deeper I wanted to explore. Accepting things as 'they were' was no longer an option and it was as if I was discovering an exciting new country. This did bring an enjoyment and vitality to my practice and prevented my practice from becoming routine and stale. Indeed, I would suggest that this is one of the main advantages for practitioners engaging in this type of reflective inquiry.

The negative side to this has been the drive to continue until I felt I had achieved the desired result despite the personal and family costs this has meant. There were undoubtedly times when it would have been appropriate to abandon the work or to have stopped at an earlier juncture, for instance to have completed the individual needs analysis rather than progress to explore the artistry within my own practice.

The evolutional nature of the work meant it was difficult to fully explain the nature of the work while it was in progress. Inevitably this did lead to some people rejecting it out of hand especially when they were approaching medical research from a more 'accepted' standpoint. When I commenced the research in

1997 it was very unusual to undertake qualitative research and I was told in no uncertain terms by a research committee overseeing Senior Registrars' projects that this was a waste of time. Notably in the next few years there was an acceptance that qualitative research had a place within medical research even by this research committee, who asked me to supervise a project for them.

However, within mainstream medical not nursing circles, my observation is that these studies remain located in the methodologies that have the most semblances to quantitative studies. For example many published in the British Medical Journal (Benson and Britten 1996; Butler et al 1998; Hopten et al 1996; Kai, J. 1996; Kavanagh and Broom 1997; Kumar and Gantley 1999) use grounded theory, which has a clear structure to its methodology and results (Strauss and Corbin 1998). Certainly these felt more understandable to me when I was first introduced to qualitative work and I suspect this is true for many other medical practitioners. When qualitative studies within medical journals are published it appears to me that the authors have to conform to a standard presentation which I think is unsuited to do justice to this genre of work. In my opinion when I read these studies it is difficult to determine whether the study itself is flawed or whether it is simply the format into which it has been forced that presents it poorly (Egerton et 2005). Unsurprisingly then it was difficult for my work, which was pushing the boundaries within qualitative circles, to be understood or accepted. At times this was very painful for me personally but it did mean that I had to be sure about my work and determined to continue pursuing it, even when it felt that both myself and the work was being rubbished.

As this study continued to evolve the pressure I came under to conform to the more traditional genres within qualitative research itself surprised me. Looking back part of the reason for this was my own perception that having 'discovered' the bigger world of research in which diversity and questioning was valued I expected this to foster a climate open to challenge. However, I had underestimated how threatening and difficult change can be for all of us and I think, how quickly new ways of thinking develop their own traditions and expectations of conformity.

Certainly confusion arose with regard to the portrait of practice and this was contributed to by the way the work developed. Frequently people on first encountering the portrait expect this to be an ethnographic format albeit of a slightly unusual form. However, the portrait is an entirely distinct genre as I discussed at length earlier in the thesis. Hence the interviews themselves are the background information that informs the pen portraits, which then become the data for the portrait itself; as opposed to the interviews being the data as they would be in an ethnographic work. This was why I laboured this distinction in chapter six. I did come under pressure throughout this study to conform to this expectation and found myself needing to defend this distinction right up to the end. In some ways it would have been easier to capitulate and sometimes I was tempted to do so but I would not have remained true to the vision I had caught of the artistry within my own practice. I believe it was worthwhile and I hope it will inspire other practitioners to pursue their own visions.

An area I had to struggle with initially was the value of my own voice and therefore subjectivity of this work. In an era when quite rightly there is an emphasis on listening to all of the 'voices' involved in healthcare including the other professionals and the patient involved, it is easy to forget our own individual and unique voice. I was exploring my own practice not the other professionals involved, of course discussions with them were important as it influenced my judgements but in the end it was my judgement not theirs that was being explored. Equally there will be aspects, or ways of regarding the practice, that other professionals will feel they would have considered and although these may be very valid and appropriate for discussion they are not included in the portrait because it is my vision of the episode of practice not theirs. I had to learn to be comfortable insisting on the validity of my own unique voice and that has enriched my own practice. In saying that I certainly do not mean that I ignore the patient's voice or those of the other professionals within the multidisciplinary team but rather recognising my voice adds depth to my judgements.

As I approached the end of my journey, the framework for the thesis began to crystallise and I had to grapple with conveying the study adequately to do justice

to the research. One particular struggle that I encountered was achieving the correct balance between subjectivity and objectivity. This has perhaps been the most challenging of all.

Initially I struggled with the concept that it was permissible to write in a subjective and personal manner. This was very unusual in my experience within medical circles and certainly not something I had seen in recognised published medical studies. Once I became accustomed to this I then swung to the other extreme and indeed enjoyed the freedom of writing from this perspective. This certainly facilitated my reflections on my practice and actually writing them down helped me to acknowledge their value. I found myself writing about other aspects of my practice, including some creative writing, quite unrelated to this piece of research. There is no doubt in my mind that this has and will continue to enrich my professional life.

The next challenge was learning to use writing to communicate my thoughts to others, not just as a means for my own personal reflections. I have never had a particular aptitude in English and this was the subject I struggled with the most at school. The principles of grammar were not formally taught and it felt that in many ways I had to go back to basics. There were times when I did become very discouraged by this aspect and I nearly gave up on several occasions because of this. Although I will not claim my writing skills are excellent I think they have improved and the learning experience has been worthwhile. My hope would be that these skills could continue to improve.

As I approached the final version of the thesis for submission the tension between subjectivity and objectivity intensified. This was one of the main topics of discussion within supervision and I was encouraged to avoid presenting the work too subjectively. My supervisors, understandably, were concerned that this might prevent the work being accepted and we all agreed that care had to be exercised in this area in case the work was seen as too radical. However, the opposite occurred and the thesis was criticised for presenting the work from a far too objective perspective. This has entailed some major revisions being undertaken and I felt I had to back track in some ways. This chapter resulted

from those revisions and within this I have taken the risk of being very frank and open concerning my own personal reflections.

On balance, I personally do feel this has added a depth and richness to this work but of course sharing my thoughts so openly does leave me in a vulnerable position. This aspect, I feel, should not be underestimated by other practitioners choosing to embark on a similar study or inquiry. There will always be an element whereby the researcher will be open to very personal criticism that would not occur in a more 'standard' research project, simply because you share part of yourself. Equally the tension between subjectivity and objectivity will always remain in similar studies and there cannot be an absolute answer to this dilemma. I suggest that each reader will have their own opinion as they read this work because they will be responding subjectively to the work and in this genre that is very appropriate.

THE VALUE OF THIS WORK

As I draw my personal reflections to a close it seems appropriate to spend some time considering the value of this work to me in particular. I have already outlined areas where I feel my practice has been impacted and the possibility of other practitioners being influenced by this. However, I would like to take some time to consider at a very personal level the impact this journey has had on me.

The most important benefit to me personally has been the realisation that reflecting on my practice is both enjoyable and rewarding. Through these reflections I have come to recognise some deeply held beliefs regarding my professional life that I had up until this point not been aware of. In addition to recognising their existence I have had the opportunity to thoughtfully consider them and develop my understanding of them further. One of these is my belief that a doctor is a healer and in chapter three I spent a lot of time exploring my personal view about the process of healing. These are personal reflections that draw on the available literature and certainly are not presented as an exhaustive critique of the literature on these aspects. Prior to this I had not realised how

strongly I felt about being a healer, which for me encompasses far more than being a competent technician and why I frequently feel uncomfortable about developments I see being imposed on doctors. Equally I now understand the reason why the most rewarding part of my job is when I am working with individual patients and therefore, the area of my work I am keen to protect and prevent from being eroded further by management pressures. This helped me make sense of many emotions I experience in my professional life.

Alongside this I have been enabled to consider some of the dilemmas I face in my professional work and clarify why these are problematic for me. One of these areas is the impact of evidence-based medicine on my practice. I did not intend to critique the role of evidence-based medicine but as I have come to the end of this work it is evident how reflections about this have pervaded the thesis. I think this demonstrates the extent to which it is influential in my professional life even though I may not have been fully aware of this.

I have come to realise that I feel evidence-based medicine, in the current form that I experience in my working environment, actually detracts from excellent medical practice. From my perspective it promotes a technical-rational view of medicine and denigrates the professional nature of my work. My view is that true professionalism encompasses the technical aspects but places the moral dimension at the heart of professional practice. This links into my deeply held beliefs about my role as a healer and the nature of a professional, both of which were foremost in my reflections on the episode of practice.

I do realise some people will take issue with this view but this is offered as my own view which has arisen from my experiences as a practitioner and reflections on this. I have also found other practitioners who share these views with me so that I do not hold them in isolation from the community within which I practice. I would suggest these concerns about evidence-based medicine expressed by some clinicians at the coalface need to be debated. Unfortunately, it seems to me that in the current climate to express these concerns is very risky and often provokes ridicule, because there seems to be an unerring belief that it is very obvious that adherence to evidence-based medicine equates with a 'good'

doctor. I have seen this happen in educational meetings and results in any dissenters being silenced very quickly. I have expressed these views strongly because it reflects how I feel and the frustrations I experience about this issue.

Personally this experience has been deeply rewarding for me because I have learnt to value the artistry inherent in my practice and I feel I have an effective means to explore and develop that aspect. This is true for both my clinical and research practice.

I would suggest that using the artistic/holistic paradigm to explore an episode of practice could be compared to the process suggested for evidence-based medicine teaching sessions but with very significant advantages. The first step in an evidence-based medicine teaching session is to identify the question to be asked and once this is established to conduct literature searches, select relevant papers that are critically appraised and then to answer the question. In the many sessions of which I have been a part, the question is dictated by the need to be answerable through preferably randomised controlled trials rather than the relevant issues within the practice. For example, in Elsie's case an appropriate question in this instance would be 'Which is the best antidepressant for this woman?' Yes there would be relevant studies to critically appraise and from these options would be identified. Certainly I would expect any practitioner to be aware of these. However, the answer would contribute very little to Elsie's case. The question that clearly arose as I wrote the portrait of practice was 'What does healing mean for Elsie?' There are no clear-cut answers from published studies, we are faced with a complex individualised moral issue. Studies, literature and our past experiences can inform the deliberations and it is these deliberations which will inform our professional judgements that will have the greatest impact on Elsie's well-being. The portrait of practice and critical appraisal of it are, I suggest, well placed to recognise and address the relevant questions.

In my opinion the artistic/holistic paradigm draws out the questions within an episode of practice but unlike the evidenced-based medicine model is able to address all of the issues that may be relevant. This paradigm promotes a

reflective inquiry which I believe is itself an artistic research endeavour. I would hope one day that as a community of practitioners we will be able to embrace this as the gold standard for educational practice and discard the restrictive model currently in vogue.

Therefore this work has been of great value to me personally and I believe will continue to be of benefit. It has validated me as a professional and enabled me to crystallise and understand some of the dilemmas I live with in my everyday practice.

THE WAY FORWARD

The way forward for me will be to continue using this means of research for my own ongoing development. In addition, I will continue to promote the use of the artistic/holistic paradigm with fellow practitioners to foster a fuller understanding of our own profession and practice. As professionals we must embrace our individual and our collective development. Alongside this we must address the need for meaningful accountability to society at large. We cannot, and must not, leave this to someone else.

I would like to finish with a quote from Donald Schon regarding the role of the artist within society:

> The artist gives us new ways of looking at our experience, new ways of defining ourselves in relation to reality, and in the process frees our awareness of phenomena incompatible with settled theory.
> (Schon 1971, pp. 131-132)

This perhaps sums up the reason why we need to discover the role of the artist within science, and particularly within medicine at this time. More than ever, with the emphasis in our society so firmly placed on technology and certainty, we need to rediscover the inspiration that only art can provide, otherwise we risk stagnating. To go forward, science and art need once again to become integrated so that practitioners can appreciate their inherent creativity.

APPENDIX 1

Letter to Patients

Dear --------

Thank you for agreeing to take part in this study. I am one of the doctors working in the Elderly Mental Health (EMH) Team and I can be contacted at ----------, telephone number ---------- if you have any questions regarding this study.

The purpose of this study is to look at what you feel are your needs and whether our service really does meet your needs both now and later on. This will give us the opportunity to review our current service and plan future changes to improve things.

There will be a series of interviews starting today, followed by another in about one month's time, and then about every three months. During these interviews we will look at what you feel you need and whether the EMH team is meeting these needs or not. I would expect these interviews to last about one to one-and-a-half hours.

I would like, with your consent, to tape record the interviews so that I can accurately record what is said. The tape is wiped clear at the end of the study. Any transcripts of the interviews will not identify who you are. The only people who will listen to the tape recording will be myself, my supervisor and one other person helping with the study. The tapes will be kept securely so that no-one can get access to them.

You are, of course, free to withdraw at any time from the study without needing to give reasons. This will in no way affect or prejudice your care within the EMH service.

Your help in this study is very much appreciated and do feel free to contact me at any time should you have any queries.

Yours sincerely

Dr Janet B Daoud
Senior Registrar, Elderly Mental Health

Letter to Carers

Dear --------

Thank you for agreeing to take part in this study. I am one of the doctors working in the Elderly Mental Health (EMH) Team and I can be contacted at ----------, telephone number ---------- if you have any questions regarding this study.

The purpose of this study is to look at what you feel are the needs of your relative, ---------- and whether our service really does meet your needs both now and later on. This will give us the opportunity to review our current service and plan future changes to improve things.

There will be a series of interviews starting today, followed by another in about one month's time, and then about every three months. During these interviews we will look at what you feel you need and whether the EMH team is meeting these needs or not. I would expect these interviews to last about one to one-and-a-half hours.

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Your help in this study is very much appreciated and do feel free to contact me at any time should you have any queries.

Yours sincerely

Dr Janet B Daoud

Senior Registrar, Elderly Mental Health

APPENDIX 2

Case Study 1: Mr Z

This 82-year-old gentleman was referred to the EMH team by his GP because he had dementia, which had been slowly progressing over the past two years but his wife was finding it increasingly difficult to cope. The referral was initiated following a recent cataract operation, which it appears both Mr Z and particularly his wife had placed high expectations on solving their problems, but it had made little difference.

The couple had been married for over 50 years and this was Mrs Z's second marriage; both of them described their relationship as always having been difficult. Currently they were living in a bungalow where they had been for the past 13 years.

Apart from developing epilepsy at the age of 14 following a fall, Mr Z had been very fit until recently. Over the past three years he had begun to experience transient ischaemic attacks, that is mini strokes, and a malignant melanoma had been removed two years earlier. A few months prior to the referral he had had a fall, which resulted in a severe burn to his buttocks for which he was admitted to hospital followed by a period of respite care, which had gone well.

The couple already had a social worker, who had arranged two periods of respite care, but apart from this they had both refused any other help.

This was a particularly interesting case because it was the first I researched and on later reflection, I could see that the way the carer interacted with me mirrored her difficulties relating to professionals who could never provide the one thing she wanted – to get her husband back to the way he was. I think this was the key to the reason for Mrs Z withdrawing from the study after two interviews because she was expecting something more from me than I could give.

Participants in Case Study 1	No. of Interviews
Mr Z & his wife	2
Consultant Psychiatrist – Assessor	1
General Practitioner	1
Social Worker	1
Nurse – Key Worker at Day Hospital	2
Doctor at Day Hospital	2
Physiotherapist	1
Occupational Therapist	1

As the data collection and analysis proceeded with this case, it became clear that this 'unrealistic' need was central to the success or otherwise with this couple. Mr Z's illness, vascular dementia, is irreversible and progressive – a cure is impossible. This makes the wife's need unrealistic to have him back the way he was. A process of negotiation ensued between Mrs Z and the professionals involved during the research to change the unrealistic need to realistic needs. From my observations and interviews, this was partly successful. It certainly highlighted the issue of coping with unrealistic needs and has led me to pursue this further as a topic in its own right.

- **Mental Health Issues**

Memory problems were evident to all of the professionals involved, many also questioned whether Mr Z was depressed. There was agreement that further assessment of cognitive abilities, mood and behavioural difficulties was needed. Mrs Z did not notably cite memory problems at the first interview but rather 'He can't do what I want him to do', 'He's demanding and keeps repeating the same things' and 'He's irritable and nasty at times'. When asked directly about memory difficulties she replied that it was her memory that worried her. Mr Z himself did not mention memory as a problem but clearly stated how frustrated he was that he couldn't do what he used to and talked repeatedly of the 'fuzziness' in his head, which the doctor who assessed him felt reflected that he was aware of the memory difficulties but was unable to articulate it

further. This immediately highlights the differing perspectives of the carer and the professionals, and it was essential for this to be heard by the clinical team if their needs were to be truly addressed. It also demonstrates the importance of gaining Mr Z's view and 'tuning' into his way of expressing distress. Because of his communication difficulties, it would be easy to brush aside what he was trying to say.

- **Accepting Changes & Limitations**

There had clearly been a lot for the couple to readjust to with Mr Z's increasing incapacity. He was very preoccupied with his poor eyesight and 'head pain', and talked frequently of missing being able to work in his garden. In the first interview Mrs Z said, 'the problem is not knowing what it is', and she wondered if the pain was imaginary and whether he was being like this 'just to be awkward'. It was difficult for her to cope with the loss of her routine, which was perhaps more important for her than it might have been for other people, and finding that he got in the way all the time, with no time to herself anymore. This fed into an increase in marital friction. Several of the professionals involved cited the need to explain to both of them what was going on and why, as the social worker put it 'help the carer deal with the situation differently'. The staff at the Day Hospital were very aware of his frustrations but at the same time mindful of the problems the carer was experiencing. They were concerned to enable him to engage in activities that were still within his abilities and preferences. For example, the Occupational Therapist explored ways in which he could do some potting of plants indoors. At the same time, she acknowledged the resistance of the carer who viewed this as extra chores for her. This was seen as an important means to building his self esteem but had to be balanced by his wife's views. The Physiotherapist felt the key was to engage the co-operation of the patient and carer.

- **Disappointments**

This was a major theme for both Mr and Mrs Z and related to unrealistic expectations they both had. Mr Z was disappointed his eyesight was poor and the cataract operation had failed; he missed his garden and was upset he couldn't help his wife. Mrs Z had expected everything to 'be fine' after the cataract operation and she didn't feel that they 'were getting anywhere with the real problem being sorted' and this was despite all the professionals who had been involved. At the second interview she felt let down because a special X-ray had had to be rescheduled due to a mechanical failure, but I think she

saw this again as the professionals failing them. Their GP felt that when their hopes were dashed with the cataract operation, this prompted the referral to the EMH team, and the Occupational Therapists saw the disappointments as the main difficulty preventing the engagement of the carer. The Day Hospital doctor had a slightly different perspective and picked up Mr Z's disappointment at home – 'He tends to get a bit excluded at home and kind of feels it's not worth the struggle'.

- **Carer's Needs – Mrs Z**

Addressing the carer's needs, which as the Occupational Therapist stated 'are very prominent, almost overshadowing his', was essential to enable his needs to be met. Mr Z was concerned and felt 'she's going to crack up anyway'. Mrs Z was clearly saying she felt she was having to cope alone and it was all getting too much. Her needs had to be met to enable her to continue caring. There was a marked difference by the second interview with me, her mood was notably improved and she was able to give room to her husband to express his concerns. She talked of his need to discuss his feelings which she felt was a major benefit of the Day Hospital. The change in atmosphere was very noticeable, with them both more relaxed with each other, often joking between themselves and with me.

- **Increased Support at Home**

This was obviously closely linked with the topic of the carer's needs and seen as important by all of the professionals. However Mrs Z had something quite different to say. She was not sure she wanted what the system could offer and had felt that things were pressed on her without listening to her. For instance, because of her husband's mobility difficulties, it was suggested he should have a Zimmer frame but she was adamant it was impractical in her small bungalow; likewise with a commode in the bedroom. I have no doubt this also linked in with her 'unrealistic' need to have her husband back to the way he was, which in accepting some of this support would have been admitting this was impossible.

- **Recognise the Patient's Needs in Their Own Right**

This was seen on two levels, both to help Mr Z recognise them, as he said 'Difficult to know what I is wishing', and to allow them to be brought into focus apart from the carer's understandably almost overwhelming needs. A key to this was allowing them

both some separation and his wife acknowledged the need for this at the second interview. Because of her distress, this had to be picked up by the team and acted on before she could verbalise it for herself – an important factor if a team is going to be needs-led.

- **Marital Friction**

This was recognised by all involved and commented on by the social worker, who said 'Their fraught relationship is colouring the carer's ability to care'.

- **Physical Health Needs**

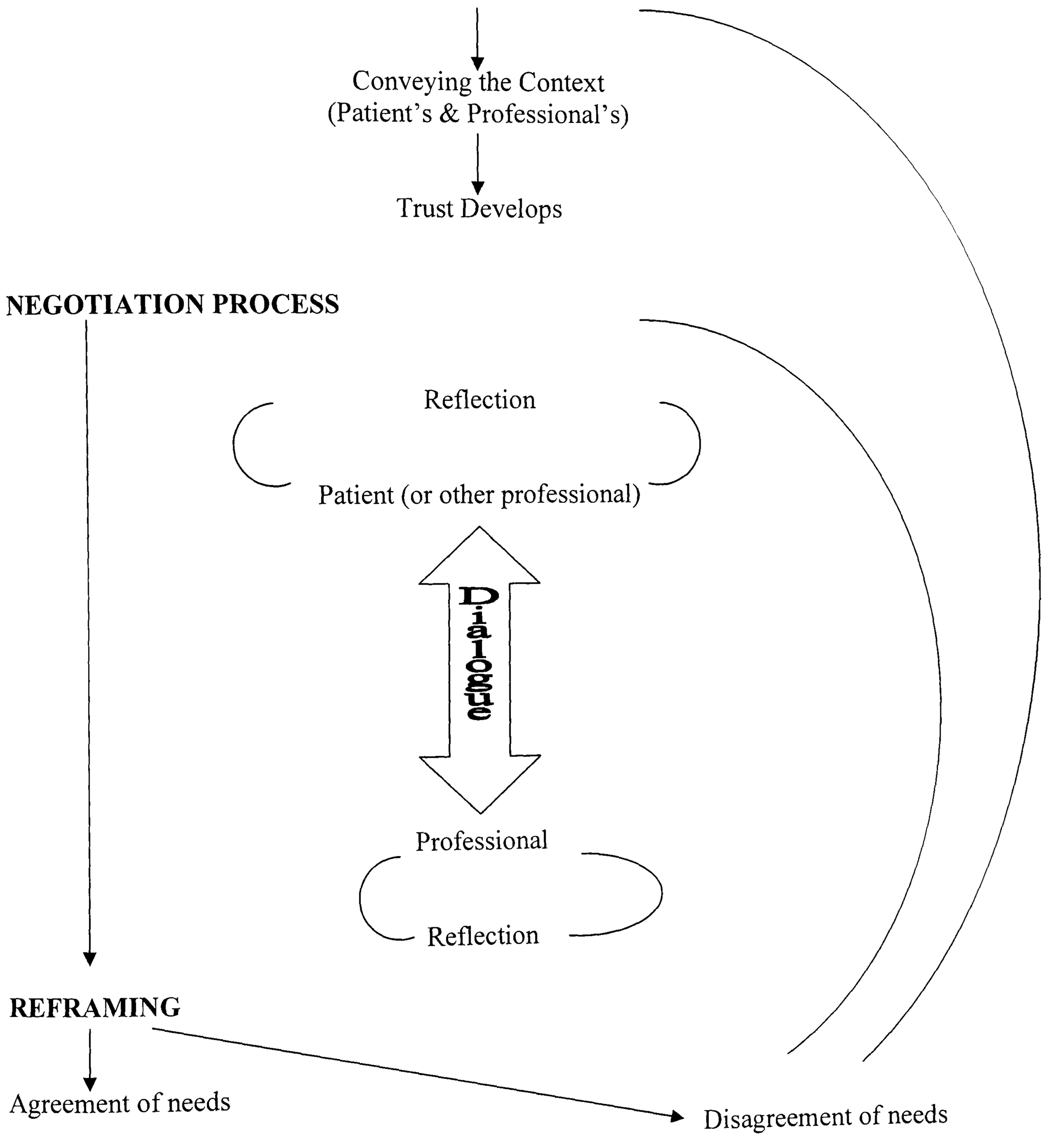
These were a major concern for this couple and the need for Mr Z's physical problems to be acknowledged and reviewed was recognised by the team.

- **Unrealistic Expectations**

Addressing these expectations was the central or 'pivotal' need around which all the other needs revolved, and they coloured all of the interactions between this couple and the professionals involved. The Assessor talked of facilitating their recognition of needs by explaining what is possible, describing an essential part of the needs assessment that occurs in clinical practice – negotiating a common understanding. The Day Hospital Doctor put it this way: 'The patient needs help to get balance between what he can honestly expect and how much he's got to live with'. A shift was beginning to occur as was evidenced at the second interview. However, it was a process that was occurring over time and how far it would have proceeded is impossible to know. I was unable to follow this case further and shortly after the couple withdrew, Mr Z had a major CVA (stroke). He was placed in a nursing home and was discharged from the EMH service.

APPENDIX 3

Process of Needs Assessment



APPENDIX 4

Subject 6 Themes 1

1. Relationship Problems with Husband

S - But D was insulted each time we went up. The third time he sat down and D walked in behind me what did they bring you for? I said 'I brought him to see you it don't look like it's worth it does it?' 'Well I don't want him here'. We'd only been there about two minutes picked up my bag I said D come on. He said 'Where we going?' One of the staff walked out and said how come you're gone already I said when my husband can speak to my D civil then I will return. And I've never been back since.

S – Oh I'll tell you I was terrified of him you know

2. Worries about son with learning disabilities

S - Then my D now he's such a lovely lad everybody loves him and my husband hates him, could never speak a civil word to him. I mean he had him put in an asylum and when I say an asylum my dear you've heard of colonies haven't you?

S – That's what he put him in at six years old. Right. Right down at Bristol and the first time I bring him out there wasn't a hair on his head, shaved it all off. And it took me how many months? Seven or eight months it might have been a bit longer to get him home. And my family my mother, she's dead now bless her, but her and my other sister and myself we did everything but we still used to go up and see D oh poor little soul. His father didn't help any but I went up one day, anyway we got him out of there after a lot of struggle. And we got him home but those days when you signed them away dear I mean you sentenced them.

J – Yes

S – And we got him home and he said he's going away again. I said I want to see where he's going first I'll know exactly where he is going. So they come and give me three

addresses the old man couldn't be bothered and me and my sister I mean I wasn't close to my mother in any way but she said fair's fair we'll all go up and see. Well we saw three and the best one was, I don't know whether you've heard of it, P Hospital, it's with Chertsey in Surrey and it was a nice place. Well he always missed you know he not like a boy the others used to say you know cause he's my saying you know what I mean. Anyway um I used to go up wind rain I'd walk to Guildford from Surrey in the snow I told him I was going and he used to watch. I hated him utterly (husband). But what happened he was at school for a year and the teacher sent for me at the end of the year and she said we've found that D's very backward. I took him to see somebody and tested him and what have you and he said we've got a tragic case here Mrs N. I still remember that all those years ago.

S - He got his finger and went through the middle of his hand he said there's the border line he's not passed that he's right on the border line. Oh dear will it goes on and on. D's nearly six and the old man had gone to work and there was this knock on the door. I was just getting ready to take D to school. 'Are you ready D? 'Ready who are you?' 'We've come to take D', my husband had signed him away. Never told me, never uttered a word.

S - He's nature mad he's got the most beautiful animals and birds up there you've ever seen he bought them and for birthdays. Now my D not my husband he's got the strength of a lion he really did and my D takes after him he's as strong as an ox he can take. My husband he used to rile my D and one day he said something he told D off and D said leave me alone. 'Who are you talking to?' 'Don't keep on at me' He went outside, D went upstairs because D's got his own bedroom. I'll tell you why in a minute. Now D has got his own bedroom he's got his own little telly up there and he's a nature lover. Anyway next thing 'heaven stop him I'll smash them all' He'd been to the shed. So I came out my bedroom cause my bedroom is my own room and he's walking up the stairs with a big sledge hammer. So I said 'What the hell do you think you're doing?'

S - 'I'll smash them all his animals, all his birds.'

S - And you mention that and that was D core D turned round and smacked him one. My D he's so gentle animals you could see that was the first time he had.

3. Recent argument and rift with other son

S - Well G up there my eldest son I think he thinks I should go but I'm sorry I am not going and that is final. I hardly see him he doesn't answer my notes.

J – You mean your son stopped?

S – My son he's such a lovely boy too.

J – But he's stopped.

S – I haven't seen him now since nearly two months. We should talk perhaps I'd be better if he talked you know but I'm stubborn. My sister down the road it's no good our N she says I'm warning you I don't want no pity I don't want anything. He's got a lovely wife, he's happy, a lovely life, no children which I'm glad in a way because my G never knew what the old man was like I never said it. He thought I'd bumped into things see.

S - But I think this last six to eight months and with G see.

J – So really it was the um the rift with G that's precipitated it all?

S – Yes and he's such a lovely boy and kind. You know by me anything he come and bought me all this. I bought this 3-piece suite for a £150 because I had to. I had to go on SS and all that and then they sent me a cheque for £500 right. And what did I do I went out I bought ------
My G bought me the rail and put it up even bought me a nest of tables and that sideboard there the old man had scratched and he came over and ------ I also bought D a bed.

J – To actually get you feeling better.

S – Mmm and I wish G would have a look. I can't understand him because it`s not like him he's been such a good boy, he's never been in trouble he's never missed a day at work you know he's a good loving he's got they both work hard she's on the Townsend Torreson. She's been made a chief stewardess and she's beautiful with it, you should see her in her uniform. He's generous with me you know when the old man first went away and I never and I didn't know what I was doing about money, he sent me a little cheque one week for £25.

4. Concerns about medication and side effects

S - Only I was getting these blackouts as well you see and of course I've got high blood pressure I'm having tablets for them and I'm frightened to take all the tablets they make me. Those he gave me I've even I daren't leave me blood pressure ones off.

J – So you saw Dr R on Monday and he changed the tablets to those and what tablets were you taking before?

S – I can't remember the name of them.

J – Was it the amitriptylline?

S – Funny name began with this P.

S – My doctor came because my two doctors were away so I had another doctor came to see me, he said I'm going to put you on some tablets he said. After a day perhaps two days I said I can't do this to me so my doctor came, 'whatever's the matters N'. 'I feel awful they've put me on these', 'We'll take you off of them'.

I'd feel all right if I could have my amitriptylline.

J – When did you stop the amitriptylline?

S – A week ago. And because J said what are they? So I gave them to her and she took them and she took the piece of paper out 'oh my God look at the side effects on here`. And I'm reading the list of side effects so when the doctor came I said the doctor came this morning to see me and he left this prescription and I want to see it first before I go and get it. He said no I'll give you these.

(Went to get tablets to show me.)

S – You'll find it on this, I think that's the one. I can't, it's no good my dear I can`t.

J – So that made you really worried when you read all of that.

S – No I was I hadn't read it, I never read that until last night after I'd taken my second one and he told me it's a milder one you won't get no see that my goodness. I'm sorry I can't take anymore.

J – So one of your big needs at the moment is to get your tablets sorted out?

S – That's what I want sorted out yea.

5. Adjustment over past year's events

S - Because I've had a hell of a life this last year and everything culminated and he had to be put away and he's in an Old People's Home. And I was all right until a little while and then I stopped going out to see him.

S - My house was a shambles, it was filthy, we got rid of furniture, he was dirty messed.

S – Well for about two years he's gradually gone down and then they took him up before Christmas. I used to open this door oh God it used to drive me mad. Anyway I used to always like and he would follow me out like all the wires out the phone like right. So this day I came in he'd have broken the wardrobe he'd the sideboard the chairs everything was upside down. He was in a little vest (laughed) he never washed or

shaved or bathed he didn't and it stunk and I thought this is no good I just can't do anymore.

6. Past memories of abuse

S - And all I meant I'll be honest with you, I've been frightened of him all my life.

S - So they said cheerio N and best of luck. I thought that's a funny remark I soon found out believe you my dear I found out. My God I've been beaten I've had ribs broken. It's the way he treated my D. And when I used to take my D out we'd walk in you know. I'm not going to swear I'll tell you because my husband every other word is f and all that.

S - I was ever so brave well that's the trouble when I did become brave I used to get thumped.

7. Relating life history

S - His mother she hated me. Do you know we had a lovely little prefab. My dear old Dad he suffered with TB, anyway he loved me D oh everybody loves old D. Anyway um the doctor said I had to get D out of the house because we were waiting you know on the housing list anyway the doctor said you've got to get him out of there. So doctor said I'll give you letter take it to the housing people which I did, you can't remember them can you them, prefabs well you wouldn't. I had one at E. Oh it was lovely and then we'd been there about 12 yrs. He used to go and baby-sit with his mother baby-sit! I promise my dear I'm not lying cause the other son M is ever an angel walked this earth he did and he died when he was young. And he stood up and he the times that man stood up to my man and his Mum. Anyway um M used to go out Friday's party night with his friends and my old man used to have to go over and sit with the mother until M came home. Can you…I'm not it doesn't sound believable does it?

S - Anyway let me tell you about P's side of the family. He had a very old aunty you know because I've found out since her side of the family they were tinkers and they had

three lots of name changes. Anyway she came to see me so one day I was telling her about D I can't find.

8. Dependence on benzodiazepines

S - Well when I went into see the doctor Dr O'C he put me on I suppose it's a what do you call it? Just calm you down.

J – Tranquilliser?

S – Ativan, well I never had it more than I should but I was taking them instead of taking three times a day I was leaving them till night time and taking three and of course that upset my system, it was stupid really like that. But what with him and I went down to the Doctor 'What the hell have you been doing?' Oh I said Dr O'C there's something wrong with me I don't know. You taking them I said yes. Now he said can you get down here tomorrow morning? I said yea I was a wreck and he and who was sitting there but Dr L. And I went into K um I came off of them rapid cured me straight away. When I came out they said to me I'd have to take a they gave me amitriptylline you know it's a mild which I've kept on.

9. Financial worries

S - Yes and he's such a lovely boy and kind. You know by me anything he come and bought me all this. I bought this 3-piece suite for a £150 cause I had to. I had to go on SS and all that and then they sent me a cheque for £500 right.

S - And I didn't know what I was doing about money, he sent me a little cheque one week for £25 got into arrears on my rent which when I went to Social Services they said oh now that Mr N has gone away you'll be relying on your pension, you won't have to pay no rent. Oh I said 'That's nice' Well it went on for weeks and then I it took them nearly just over six months to get everything sorted out. My pension well that was disgusting.

J – It took its toll out on you.

S – It's absolutely – every time I kept sending letters gone up there and every time I went saw somebody different. Oh can you tell me my dear, I've told you all about my circumstances it's all on your computer and then the girl there says oh will you hang on a minute and away she goes. She'll come back oh yes we've got that. So now what do you want? Oh something else isn't quite right. So I says all right. Anyway I'm here one day and knock at the door, nice lady it was, 'Hello' she said 'Mrs N' I says yes 'yes' she said 'I'm from the council you know I've come about your arrears'. I said 'You what!' My arrears after all those months surely somebody could have told me? Oh I said my love oh dear not something else. So that was £130 well I said 'I'm sorry I can't manage it', 'Your rent works out a £7 a week and what I'm going to ask you to do is if you can pay £10 a week then you will pay it off', which I have done but it's difficult to put by and for all I owe about £70 now I think. So when that's paid the rent comes down to £7 which is a bit better and um I'm left with tax um housing rates they don't call it that.

10. Panic attacks

S – Well a week, two weeks went by and I said to our J, I don't know what's up with me. I'm just not coming up. My legs go or rather my knees go under me. I think quite honest I have panic attacks see.

J – Are you still getting them?

S – Um not all the time but I do get them they're awful things my dear. I sat there with one of them, well she comes up every day, and I could feel it I know it sounds it starts from the feet and goes up until it's like ice bags all over me. J said 'It's alright'. 'J', I said 'I've got one of those attacks' and then you're laughing see.

J – And has that stopped you going out and doing things?

11. Unable to continue normal routine

S – I've not been out my dear since the 8th Jan. I haven't been the other side of that door.

12. Disappointed with professionals

S – No I was I hadn't read it I never read that until last night after I'd taken my second one and he told me it's a milder one you won't get no see that my goodness. I'm sorry I can't take anymore.

J – Are you feeling very disappointed in the doctor?

S – Well not in the doctor I mean they do try their best I suppose they do. But oh dear you can see them can't you?

13. Adjusting to being older

S – I mean if I was younger I could probably cope. I mean I'm 78 lover it's no good I can't cope.

14. Previous alcohol problems

S – Yea I drank solidly for 25 years and my family never knew for years and years and then, let me see 12 years I had a sister, one of my sister, she was 63 when she died and my D loved her and he was upset and he had a little weep.

S - Well I don't know what it was that made me do it but I came downstairs and I said Cheerio W, I won't drink no more. And I haven't. She knew I drank because she often used to say and on my D's life I've never touched a drop since. I can't even stand the smell of it. Isn't it funny?

15. Why now?

J – It's like it's all caught up with you now.

S – Yes and that is what the doctor said 'But why?'

J – Sometimes perhaps it catches up when you don't expect it.

S – When you don't expect it. But I'm an active person always have, well when I say always I don't go pictures, I don't drink, I don't do anything like that but I go out with D.

J – So actually it feels you've got more freedom but at the same time you've come to feel much worse in yourself.

S – I've never thought I'd feel like this my dear I really didn't.

APPENDIX 5

Developing Thoughts

Portrait of individual's journey with EMH team

Portrait of EMH team working as a needs-led service

Critical commentaries on the portraits

Critical commentaries on the pieces of professional practice

Critical commentary on research practice

? my professional development

? the team's professional development

Vibrant healthy team diet of what?

Malnourished apathetic team ?CPD

Artists:

'open the eyes of others'

'enable them to recognise and search out details that they would otherwise miss'

Artists – go beyond competency, instinctively respond to it, what exactly? Artistry?

Craftsmen – competency fine but something missing. Don't have the same feel, artistry lacking, wooden, factory, conveyer belt production.

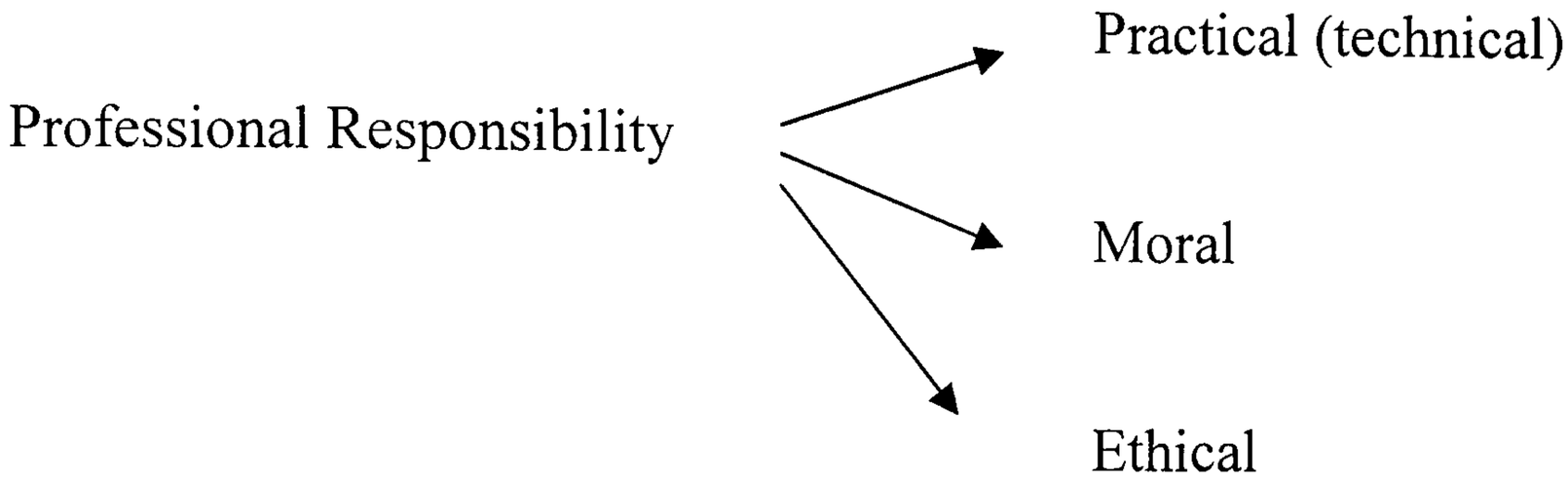
Artistry:

- Dynamic interaction with patient
- Fluid, alive
- Sensitive to subtle nuances
- Feels alive
- Unique piece of art

Artistry WILL NOT yield fully to analysis or a multi-perspective interpretation

Many things happening at the same time or one set of actions simultaneously achieving many ends

ALWAYS an irreducible element of mystery in it



i.e. more demanding

CPD

Process of evolving change from within rather than imposing change from without

Professional artistry

- achieves profession's moral ends
- moral good we seek is health of clients
- can only be made within practice
- cannot be predetermined i.e. part of process has to be creative
- formulated in theory but not fixed
- only intelligible in terms of traditions within which you are practising
- settling for more immediate goals can ultimately turn out to conflict with client's ultimate good

Appreciation

- context of piece of art is crucial
- history and traditions within which it is based
- history of practitioner
- history of whole profession

- artistic recognition separate from social recognition
- concerned with what there is to be recognised whether or not it is recognised

Draft Portrait 2

Calling this lady 'subject six' or 'N' is just too impersonal and it detracts from the portrait, so I'm going to give her a pseudonym. For the portrait I have chosen Elsie, as somehow that name sums up the era she represents and does embody something of her essence.

I observed and also became entwined in this piece of professional practice when Elsie was referred to the Elderly Mental Health Team by her GP, who telephoned saying she had become quite low and depressed again, requesting that she be visited at home.

A few days prior to my first meeting with Elsie she had been assessed by one of the doctors on the team and a management plan had been formulated.

From the moment she opened the door to me it was as if there was an avalanche of emotions pouring out from this very distressed lady. I did feel overwhelmed by it, even though this is by no means an unusual occurrence in my everyday practice. She did fully understand that I was there as a researcher, but whether I was a researcher or part of the clinical team I think was irrelevant to her at that moment. There were many raw emotions that she couldn't contain for herself, and desperation to convey to me 'herself', to be known by me as the unique individual she is. Looking back now I can see how this became a central theme in her interaction with the team. Talking with members of the team and following Elsie's journey through the service, it was evident that these feelings of being overwhelmed by her needs was common to everyone, although each individual attempted to contain them in varying ways.

These feelings are mirrored in my sense of not knowing how to convey Elsie fully to you the reader and yet at the same time desperately wanting to succeed to enable you to meet her and experience her interaction with the EMH team. I want to do justice both to Elsie and the professionals involved as they sought to comprehend the complexities that challenged them.

She had been involved with the team many years ago when she was withdrawn from benzodiazepines and, because of the possibility of an underlying depression, had been

put on a small dose of an antidepressant, amitriptylline, on which she had remained. At that time problems were evident in her marriage but had not been addressed because presumably she did not wish to. I am assuming this was the reasoning as it was not explicit in her medical notes.

Her GP knew Elsie very well and conveyed a very extensive grasp of her difficulties and the context within which they were arising. He was realistic in his expectations of what might be achieved, recognising that the system had in fact failed her many years ago and acknowledging that within primary care they were no longer able to meet her current needs. Certainly he was not viewing it from a simplistic view of an agitated depression that required treatment with an appropriate antidepressant and the crisis would be resolved. Yes, this was an integral part of it but the picture was far more complex than that. He was unafraid to acknowledge his own limitations.

Elsie was now in her 70s, living with her son who had moderate learning difficulties and relied extensively on her, and for whom understandably she felt very responsible. She had had an abusive marriage culminating in her husband developing dementia, during the course of which his unpleasant personality traits became accentuated, resulting in him recently being taken into care. Throughout their marriage she had seen herself in the role of advocate and protector of her son on whom her husband directed a large proportion of his anger. This had resulted in their son being 'put away' in an institution when he was six and eventually, after much heartache, Elsie fought to have him home again. Since then he had remained at home with her but often she would end up as it were 'piggy in the middle' between them.

However despite his abusive relationship with her, she had remained loyal to him and initially continued to visit him in care. On one occasion she had taken her son with her and he became very rude to him asking 'Why she'd brought him along?' At that point she stated she would no longer see him unless he was going to be civil to his son, and had not done so since. This caused a rift with her younger son who could not comprehend his mother's attitude. Up until that point he had been very supportive to her, helping her refurbish the house that her husband had spoilt. Maybe at this point it felt to her that he was now openly taking sides with her abusive husband. Although she always emphasised how good he had been to her, looking back she always described

this in terms of practical help, never in terms of emotional support or understanding what her husband had put her through.

She had a sister who lived down the road, from whom she seemed to be receiving a lot of help and it was at the point her sister was due to go away on holiday that the referral was triggered.

Surveying the landscape at this point on Elsie's journey, there were many dark storm clouds already on top of her, with others appearing ominously on the horizon over which she could exert no control. Perhaps the most terrifying aspect for her was the uncharted and exposed nature of this land she had been ushered into with no obvious shelter available to her. Indeed, the shelter she had relied on up until now, though far from ideal, had vanished in front of her eyes. No wonder then that she presented in chaos and panic.

I wonder whether the desperation to make us understand as professionals was as much for her own benefit as she tried to make sense of it for herself – to rewrite and rewrite her narrative until it was in a form she could live with, or should I say rework again and again the landscape into something more familiar that included places of refuge for her.

Initially it appeared that her messages were getting lost in some way to the professionals and yet it is far too simplistic to say that the professionals involved didn't comprehend the intricacies and complexities of her situation, both present and past. In fact, in interviewing those involved I was often amazed at the depth of insight they portrayed of Elsie. So why did the disharmony exist?

I think it revolved around her being able to hear her own messages and then for the team to be able to convey to her that she had been heard. It was a situation in which this dynamic had to be acted out in her interaction with the team and the team's interaction with her. For Elsie, words, however well chosen and empathic, were not enough. It took time and a lot of frustration on both sides but there was just no other easy way. That was the first hurdle and only the starting post.

Reflecting on the situation her CPN commented:

'Challenging. Actually I like her, I do, I've got very fond of her. I could have cheerfully strangled her a few times along the way, I really could. Um no it`s challenging and she has been very frustrating at times when I think we've been on the wrong track with her and she's been telling us 'No, no, no, I can`t take this medication', it's making her poorly and everything you tried is wrong. You know, it's so frustrating it was like she was sabotaging everything right from the beginning but you know I guess what she was saying was 'You're paying attention to the wrong bit'.'

A lot of the communication was non-verbal. Early on it was felt that she needed admission. The doctor's reasoning for this was both to establish her on an appropriate antidepressant but also to convey to her that yes we did take her seriously and the service did care about her. She had become very angry, feeling that neither he nor the GP had bothered about her in the preceding two weeks, the tablets weren't working and she'd been left to rot.

This transpired as an important turning point for her, even though she required two admissions and further input in the community before returning to a state of acceptable health for her. I emphasise acceptable state of health for her because in the end we must seek the individual's view not our own and this was acknowledged all the way along by the professionals. Many commented on the complex and longstanding psychological issues evident, but at the same time recognising that these would never be completely resolvable and indeed might not even be touched unless Elsie herself wanted to do so.

Looking with hindsight however, in my first meeting with her she commented that all she wanted was her amitriptylline back and in the end that's what she got and became 'well again'. I think this was actually a symbol of her life returning to some sense of order for her. Her relationship was restored with her younger son; she was now getting help with her older son and emotional support for herself. She had re-established some places of refuge for herself. From a 'scientific/biological' point of view, it was totally illogical. After all, she relapsed on exactly the same dose of amitriptylline and evidence-based medicine, as it is currently defined, dictates you must either increase the dose or explore alternatives.

This calls into question whether the healing process wasn't to do with the medication at all but was in fact the interaction with the team, whereby she navigated, with our support, her own way through her chaos. So maybe the team experiencing the chaos wasn't a failure of not hearing her needs but a central part in meeting this lady's needs. But how often, because there doesn't seem to be an immediate 'right' answer, are we programmed to view that as a failing? It isn't pleasant sloshing about in the mud, but if we hadn't done that, would we really have met Elsie's needs? Somehow I very much doubt it.

After her first discharge, Elsie had a fall and fractured her wrist. This threw her and she was readmitted to the ward. Obviously her medication was reviewed during this time but what mattered to her was feeling understood as an individual by the nurses. She commented how all the staff were different and had different ways with people but said 'All different but it all merged in'. It conveyed the sense that for her the team on the ward functioned effectively as one.

Seeing her on discharge home, she was quite clearly much improved from the agitated depression, but still tentative about her ability to cope with life as it was now. She was negotiating the rules of engagement with people; this included her family and the professionals working with her. Early on she would ensure that her sister was present when anyone visited her and her CPN picked this up:

> 'It was like Elsie needed a back up against us or she needed some strength to put her point of view across to us, and I think the sister was this strength and the sister has dropped back out of it in the last few weeks and my feeling is that she's satisfied I've heard the right message.'

She would often reiterate her boundaries, stating how important it was for her to be given a choice and for people to say 'would you like' rather than 'you should'. It was at this point that I asked whether she found her view of her needs had changed because other people had suggested different things to her. Both she and her sister took this to mean was she a sociable person, and they were both at pains to explain that she was a sociable and open person but that she liked to be private and didn't like to share who

she was easily with neighbours etc. This highlighted for me how privileged we were in what she had shared and opened up to us, trusting us without really knowing us because we were professionals. That, however, also came with great responsibilities, not least to avoid overstepping the mark with her and to be very sensitive to that.

The next time I saw her she related the difficulties she had experienced with the Social Worker and as a result of these had stated she would not see her again. From her point of view, the Social Worker had overstepped the boundaries when she approached her younger son to give additional financial support to his mother. In view of their recent reconciliation, this probably felt like a major threat to that and understandably she reacted to it.

Later, interviewing the Social Worker, I was surprised how well she appeared to understand Elsie's situation, indeed better than some of the others involved whom I talked to, describing her as a very frightened lady who presented with a huge gap between what she needed and what she could take on board. It was obvious that she felt she had put in a lot of effort on a personal level, well beyond her role, to make what was available acceptable to her, but to no avail. She stressed the need to get her trust and support her, be there rather than doing, yet she appeared to end up doing and so alienated Elsie. It's also noticeable that neither of us directly tackled this issue and I sense it was skated around by all of the team involved. Part of this may be that we all recognise how painful it is when a patient directs negative emotions at you and there is a sense of the team being a living organism that does feel pain. I'm not sure we're good at admitting to it and certainly not in dealing with it.

As time went on, the issue of becoming vulnerable with increasing age and worries about the future care of her disabled son emerged as central issues. They were there in the background all the time and often professionals involved would muse that these were probably the 'real' issues but they came to the foreground as Elsie recovered. Initially she started to allude to them in passing but in later interviews she was able to voice them:

> 'I used to agitate myself you know about will I do you can't expect relations you know J's 60 odd and my brother G he's 60, no 65 and my G. he and my

daughter-in-law you can't expect them to do it isn't fair. Oh yes D was my bug bear.'

Her needs for care were increasing as she got older and previously the family largely met them but I sense this was becoming too onerous for them. The outside help was needed. I wonder how much of this was 'known' to Elsie without any words ever being spoken between them, leading to the sate of panic we met her in.

On one level you could suppose that's the final answer that we were searching for all along, coupled with an agitated depression. In traditional methods of recording health interactions, that's what it will say, but that misses the real journey we all embarked on, often in the mud of the swampy lowlands and scrabbling up steep hills. It involves so many subtleties and such richness that cannot be contained, however good the container.

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