Introduction

I first entered the physical therapy department of a local hospital simply looking for a job as a patient transporter, and as soon as I got off the elevator onto the fifth floor and into the department, I realized how different this job would be from any other I had ever experienced. Immediately to the right was a short hallway which opened up into the actual department, where people in long white coats and purple scrubs could be seen coming back and forth from desks at the right end of the room to patients in wheelchairs lined up side by side along the wall at the left side of the room. It was the patients that immediately attracted my attention. They were elderly, some with unsightly bandages on their heads, others missing limbs, and others with casts, all looking pretty worn out and unkempt. As I cautiously walked into the open space I quickly became aware of my own alien appearance within this setting in my street clothes and hoped that one of the therapists would notice and intercept me before I entered too far into the room. This of course was done as I was greeted with a smile and a “Can I help you?” but not before everyone in the room, patients included, noticed the unfamiliar redheaded kid in jeans at the corner. I was not sure how to react to the blank stares I received from the patients; I was in total confusion as to how to behave in such a setting. Do I acknowledge the patients or simply act as if I hadn’t noticed them? Luckily, the therapist took me back into one of the offices to fill out an application and left me to mull over what had just occurred.

Perhaps Benedicte Ingstad best summarizes how I felt in his work, Disability and Culture: The tendency within American culture in dealing with disability is to treat it as unspeakable and invisible. Children are taught not to point, stare, or mention the impairments of people they meet. And so we are treated with the paradox of nobody seeing the one person in the room of whom they are most acutely, and uncomfortably aware (Ingstad 9).

My initial introduction into the physical therapy department under study was very much in tune with this statement. My feelings of uneasiness and
unfamiliarity from this encounter emphasize just one of the many contrasts that this physical therapy department has from daily American life, and thus sparked my interest in conducting an ethnography of the interactions and views of the physical therapists who confront situations such as disability on a daily basis.

**Research Methods**

The particular department which I am investigating works within a surgical hospital, so the majority of the patients that come into the department have undergone some type of surgical procedure, typically knee and hip replacements and back surgeries. Many patients however have had debilitating strokes and have lost total mobility on one side of their body, and other patients have had limbs amputated as a result of growing difficulties with diabetes and bad circulation as they grow older. The greatest extent of my research was conducted as I followed through my tasks as a transporter for the department, every Saturday and Sunday from 8am to 4:30pm. My responsibilities as an employee are to go to each patient’s room to ask them if they are ready for their session. (It is important to note that they do have the right to “refuse” therapy.) If they say yes, I then safely assist them from their bed or chair into the wheelchair or stretcher, and take them to the therapy department. In doing this, I experience first hand the patient’s feelings of dependency on others for simple tasks. I also take the patients back to their rooms after therapy is over. I have access to patients before and after their sessions and am therefore able to inquire as to how they feel their session went.

**Evaluating a Research Question**

Over the course of my observations and readings a number of relevant themes have emerged on which I have primarily focused, such as what therapists consider to be the main factor in determining and evaluating what type of therapy to administer on a patient. Some questions I wished to answer was how familiar the therapists were with the patients on a personal level, how important they feel this knowledge is, and the ways in which they instigate such knowledge. Also, what is the impact of family relations on the therapy process and how much does patient motivation affect the therapist’s interaction with each particular patient? These questions, among many others, emerged throughout the process of my research and observation and constitute the focus of my study.
As I began working, my experiences with the patients initially prompted me to undertake an ethnographic study of the ways in which patients who have experienced some form of illness or disability as a result of aging cope with their particular losses. I wanted to examine how age determines the attitudes of the therapists concerning the physical malady, and how this in turn affects the type of therapy administered.

In order to answer these questions, it would have been necessary for my research to include both the patient and physician aspect of the therapy department and how the two interact accordingly. Just a few questions that I wanted to address were how the patients view therapy, and how do these views coincide or conflict with the physician’s views? If a patient realizes that he or she may not recover fully, how does this affect their world-view and how they see themselves within it? Do they assign themselves an inferior status, as Ingstad proposes American society does to individuals with disabilities? (Ingstad 9) Do the patients consider themselves disabled? How willing are they to accept assistance in simple tasks, and do they feel like this threatens their individuality?

There were many ethical dilemmas with these questions however. Since the patient’s uncertainty about the future may cause a great deal of anxiety and stress, they may rightly feel uncomfortable talking about their ailments and the unknown future that their particular ailment might bring. This would have made interviewing patients very difficult, for I would have had to present questions in a non-troubling manner so as not to dismay patients further as to their condition, but at the same time attaining relevant data. I would have been forced to ask direct questions about one’s impairments, forcing patients to acknowledge their own inabilities at a time when they may not be ready to do so. Given this ethical consideration, I decided to shift my focus onto the views of the therapists on many of these issues.

**Literature Review**

Although there has never been an ethnography carried out among an American physical therapy department to my knowledge, many articles have been written about the relations between patient and physician. Also, there is relevance to this topic in anthropology among the various studies examining the concept of disability.

A very relevant article to the current research proposal is Gay Becker’s *Managing an uncertain illness trajectory in old age: patient and physician*
views of a stroke, in which he outlines three stages of Anselm Straus’ concept of “illness trajectory.” These three stages include the medical diagnosis or the physician’s view, the time-span encapsulating the “sickness” of the patient, and the “personnel narrative” or the patient’s view (Becker 166). Becker emphasizes the uncertainty felt among patients as to whether they would be able to return to their normal lifestyle. This uncertainty is a significant catalyst for anxiety among patients, and they are thus likely to falsely assume that if they work hard enough, rehabilitation will eventually cure them of their predicament.

Physicians, on the other hand, base their views on biological knowledge and are aware that rehabilitation is not a cure, but nevertheless may still be utilized as a useful psychological comfort. Physicians place patient motivation and a positive attitude as the main factor in possibly regaining lost abilities. Becker goes on to identify five components involved in the physicians’ evaluations of a patient’s “recovery potential.” These include the physical abilities before the affliction, the ability of the patient to perceive his or her surroundings correctly, the severity of the condition, age, and the willingness and ability of the patient to undergo and challenging therapy program (Becker 168).

This particular research conducted by Becker and the necessary terms such as “recovery potential” within will prove essential for this study for I am interested in how physicians weigh the particular components of “recovery potential.” Also, at what point does a physician give up on a patient citing lack of motivation and improper attitude, and if this occurs, is this action justified?

In another article, Rita M Riani examines this relationship between physician and patient as well, asserting that physicians can lessen the degree of physical suffering among the patient by recognizing the connection that physical ailments may have on an emotional and psychological level. Riani examines these issues using Alderian theory, which asserts that peoples’ patterns of behavior and attitudes are developed by social interactions experienced in early childhood (Rule 208). Based on this theory, she asserts that the adopted beliefs and values of an individual throughout his or her life will greatly influence the degree of his or her success in rehabilitation, and she stresses the importance of patient motivation and attitude when undergoing therapy. However, she also places great importance on the knowledge of the therapist concerning their patient’s history, beliefs, and values, which would greatly help the therapist in decision making, treatment approaches, predicting the patient’s future behavior, and goal setting (Rule 214). She in turn emphasizes the physician’s ability to identify behavioral patterns as crucial to the
rehabilitation process.

John Janzen defines all those involved with the rehabilitation of an individual as the “therapy management group,” therapy management in turn consisting of both the formulation of a diagnosis and the prescribed therapy, as well as those present when this therapy takes place, including family and physicians (Janzen 69). He defines the therapeutic process as:

A series of actions occurring in a social context in which individuals living in ordered relationships or roles, make decisions about their own welfare… on the basis or partially shared classifications, values, and knowledge. Such therapeutic acts thus mediate differing classifications and values (culture), social structures or roles (society), and protagonists’ assessments of the effectiveness of the therapy (Janzen 76).

He emphasizes that therapy is a process, the consequences of which include a “role transforming experience” for the patient, although just another day at the office for the therapist. My research will further examine this concept of “therapy management group” and explore the ways family relations affect the therapy process.

**Main themes**

My observations in the field have yielded a number of basic conclusions, five of which are outlined in this current study: 1) motivation is considered to be very important among the therapists and employees of the hospital, despite some therapists’ tendencies to downplay its significance; 2) knowledge of a patient’s personal life is considered important, but mostly only in terms of finding out who will be there to take care of the patient after they return home; 3) the role of the family plays an extensive part in the therapy process both as a motivator as well as a determinant for future care procedures; 4) therapists may indeed tend to promote therapy as a “cure” in order to motivate a patient if other means have been exhausted; 5) patient independence is the ultimate goal.

**Field observations**

Two of the three therapists interviewed cited patient motivation as the single most important factor in the therapy process. One even went so far as to label the role of the therapists to be that of *Motivator*, saying, “the bottom line is if they don’t want to do it, they’re not going to. You can try everything in the
world but if they don’t want to they’re not going to.” Another therapist said motivation is a great tool to use “if you can find what gets them going. For instance, if you know someone’s a mother, you can say, ‘Oh you can do this! If you’re a mother I know you can do this!’ and 95% of the time they end up doing it.” In contrast to this statement, however, this same therapist labeled motivation as the least important factor in therapy, saying, “Motivated or not, you still got to do it”. She went on to point out that therapists must establish short term and long term goals with a patient and that even though lack of motivation in a patient may lessen the short term goals, the long term goal always remains the same: independence. These discrepancies are somewhat troubling, but from my own observations and work experience, I would have to conclude that motivation does indeed play a crucial role, because, as I have observed in many separate situations, if a patient does not wish to participate in a session, they have the right to refuse and often do.

One instance in particular is worth citing in its entirety from my field-notes. It was taken over the course of two days regarding one patient’s refusal to attend therapy, despite his nurse’s insistence that he go. Ignoring the patient’s refusal, the nurse placed him in the wheelchair to go up to therapy anyway. The patient, whom we shall call Mr. Smith for privacy considerations, continued to voice his refusal while in the department, and the therapist sent him right back down to his room without therapy. This incident occurred on the weekend of April 12, 2003.

I came to get patient after lunch. (Patient had already refused his morning session.) When asked to go therapy he shook his head no. I asked why and he said, “I just don’t want to go. I just want to go home and sit on my front porch.” Seeing this as a possible means of motivation, I replied, “I understand that, and if you come up to therapy, your doctor may let you go home earlier so you can sit on your porch.” He thought about it for awhile, and then shook his head no again. I told his nurse, and she said that he needed to go because his doctor was going to send him to a rehabilitation hospital, Cardinal Hill, and if he kept refusing therapy here, they would not accept him there. She went into his room to try to convince him to go, “You need to go to therapy to get better. Don’t you want to get better?” He replied, “No! I just want to go home and sit on my front porch!” After many more similar exchanges, she finally started to physically sit him up in bed. He did not resist physically, but with verbal resistance, almost pleading, “please don’t make me do something I don’t want to do.” He then looked at me, as I stood by the door watching. “Sir, sir, would you make a man do something that he doesn’t want to do?” Although my internal reply was no, and I felt as if what this nurse was doing
was wrong, I replied cautiously, so as not to rebuke her actions, “If it would help that man get better, yes.” The nurse continued to place him into the wheelchair despite his constant moaning and verbal refusal. He was almost at the point of tears. I knew that the therapist would not work with him like this, but took him up anyway, with him moaning and reiterating how much he did not want to go the entire way. Once up in therapy he continued to moan even louder and exclaimed “I just don’t want to be here!!” The therapist replied with a frown, “It sounds like you just don’t want any rehab is what it sounds like. We thought that you were going to Cardinal Hill to try to be independent and stuff.” The patient continued to moan and refuse, and the therapist said shortly, “OK, we’ll take you back and tell the nurse you were in pain.” He replied, “Why don’t you tell her the truth?” “Well, what is the truth then?” “I just don’t want to be here!” The therapist frowned again and said OK. She then walked over to another therapist and said heatedly, “If he’s not going to do anything, I’m not going to make him. Take him back. He’s supposed to go to Cardinal Hill but they won’t take him like this.”

This incident is very important for understanding many of the main themes: it demonstrates how motivation is the crucial factor in patient participation in therapy, it shows the point at which the therapist may give up on a patient, and it also demonstrates how employees may try to coerce a patient into coming to therapy.

Mr. Smith was incredibly obstinate in his refusal to attend therapy. It is evident here that the therapist’s statement about motivation does not apply in this instance. He is determined not to do it, and he won’t, despite the pleas of his nurse, transporter (in this case myself), and therapist. From this instance alone it is clear that a certain degree of motivation must be present in a patient in order for them to carry out their exercises, and therefore it is a crucial ingredient in rehabilitation. So the question must then be asked, why did one therapist downplay motivation so much?

A possible answer that I have determined lies in the role of my job within this particular department, the transporter. As I explained earlier, it is my job to take the patients out of their beds, place them in the wheelchair, and take them up to the therapy room where they are then seen by the therapist. A possible explanation for the diminished role of motivation in the view of this particular therapist is the fact that every patient she sees in the department was at least motivated enough to get out of bed (a process which alone can be very painful and tedious) and come up to the therapy room. In contrast, every patient that lacks this minimal level of motivation would have refused my efforts to take
them to the department and remained in bed. Thus, simply put, the therapist sees the motivated patients whereas she does not see the unmotivated patients, and therefore motivation would likely seem as of little significance, whereas from my point of view, motivation is crucial. With this being said, motivation is seen to play a dominant role in application of rehabilitation.

Another significant point about this particular instance with Mr. Smith is the dialogue between the nurse, myself, and the patient. Upon first refusal he gave me a reason why—he wanted to go home and sit on his porch. I picked this up immediately as a possible motivating tool (using the patient’s own desire to go home as a means of motivation is echoed in the interviews by every therapist). This however, did not convince Mr. Smith and he continued to refuse. I informed his nurse and she again reiterated to him that therapy would help him get better. Both of us implied that therapy would in fact improve his current condition, as it most probably would. But the fact of the matter is that we both emphasized it as a possible means of curing, and not simply as a process of rehabilitation, thus encouraging the illusion of therapy as a cure as Gay Becker discusses. Although I realized that I could have been perpetuating this illusion while I made those statements, I felt forced into it by the insistence of the nurse that he go and the patient’s own insistence that he not go.

The third major theme of this particular instance is the therapist’s unwillingness to work with him while he remained so obstinate. She feebly tries to convince him, frowns at his refusal, and finally waves him back down to his room saying “If he’s not going to do it, I’m not going to make him.” Once again, patient motivation is the main element here. It is, however, important to note that Mr. Smith’s name was on my list of patients to bring up to the rehab room the next day as well, insinuating that she had not totally given up on him. This next account with Mr. Smith is as follows:

The next day: Patient was on my list again to bring up to therapy. Once again, he refused in the morning with a shake of his head, and I told him I would check back after lunch, which I did. He was asleep. I woke him, and was very surprised to hear that he would agree to go to therapy without objection this time. He took his time getting out of bed and politely refused any help saying he wanted to do it himself. He worked himself to the side of the bed slowly with many rests and I helped him into the wheelchair. Just before doing so he told me that he dreamt about me last night, and that he never hated anyone more in his entire life. I smiled nervously and asked him if he hated me now, and he said no. He then said that his wife called today and refused to bring his
grandson to visit if he wouldn’t cooperate with the therapists, and so now he said he would do anything we asked him too. Once in the department, he was welcomed back with all smiles, “Well look who’s back! Good to see you Mr. Smith. How are you doing today?” He cooperated with every request to the best of his ability today.

Perhaps the best example of how these incidents coincide with the information gathered from relevant literary sources is that of Mr. Smith’s agreement to cooperate with therapy only after his wife refused to bring his grandson if he would not. This fits in very nicely with John Janzen’s concept of a “therapy management group”, or all those in the therapy process. With this particular incident, the family was a crucial means of incentive to improve and cooperate with the therapists, which greatly emphasizes the effect of the family on the patient’s motivation. On having knowledge of this particular motivation for Mr. Smith, the therapist then used it to her advantage by encouraging the patient to keep working at his therapy so that he could pick up his grandson, etc. In this instance having a general knowledge of a patient’s personal life proved to be of great benefit.

When asked about how important they felt it was to get to know a patient on a personal level, most of the therapists interviewed agreed that it helps, but is not really necessary. One commented, “It makes it easy, but you don’t want to delve too much into their personal lives because it can make it complicated. You don’t want to get off track”. Another said that patients will generally work harder for you if you get to know them personally. The overall consensus however was that a certain amount of knowledge was needed as to what their home situations were like, whether or not someone would be there to look after them if so required. The therapists are only able to meet with some patients about 15 minutes a day, and therefore don’t have the time to develop real close relations with patients, so they generally focus on what is relevant to the situation, which is learning about possible caretakers after the patients leave the hospital. One therapist said that she generally gets that information from the patient’s chart, while another found a more personable method of asking and said “I always ask where they’re from and about the area and try to relate to it personally with my own home somehow. I also ask who will be there when they get home. That way you learn about their family dynamics, but it comes across as you asking about them and helps you do your job as well. It makes them trust you and lets them know that you care about them and don’t see them as just another heart patient.”
This certainly seems to be the case from my observations. Patients that I had made an effort to get to know and converse with were generally more willing to make an effort to come to therapy with me, despite the level of pain they were experiencing. One particular instance was with a certain male patient in March who had had his leg amputated. His nurse warned me that he would be uncooperative and rude, so I was prepared for anything when I knocked on his door. I asked him if he would come to therapy with me and he replied curtly and almost reluctantly, “I guess”. Then he said, “Well sit down and hear my story,” so I sat down in a chair and listened as he explained to me that in December he had his leg amputated below the knee and underwent therapy then. He was now back again to get more removed, this time just above the knee, “So you see, I’ve gone through all this shit before.” He was pretty put out about it, but nevertheless was willing to cooperate with me every time I came for him, and even cracked a few jokes now and then. His nurse came up to me later that day and was shocked to hear that he had given me no problems. Simply listening and getting to know this particular individual had resulted in his cooperation with me whereas he was uncooperative with other employees.

From my experience I found that this proved to be the case with many of the patients. One woman in particular had a knee replacement. She refused her morning session due to intense pain, so I checked on her again after lunch to see if she was feeling better. She was still in a lot of pain, but agreed to try to come. Getting her out of bed was extremely slow and difficult and she was constantly commenting on the pain she was feeling, so I tried to get her mind off it by talking to her a bit. I ended up telling her that I was an Anthropology major at UK and she immediately lit up. She started talking about programs she had seen on the Discovery Channel about old civilizations and she told me everything I ever wanted to know about Pompeii. I told her that I would love to travel to Europe to see it, and she then said that she’s love to see the cave paintings in France as well. I agreed. It is significant to point out that in the twenty minutes we talked, she never once mentioned the pain again and was clearly feeling better. Color was restored back in her face and she was smiling cheerfully. After her session I put her back in bed and before I said goodbye she stopped and said, “Andrew, if you ever get to see the cave paintings in France, think of me.” I assured her that I would.

Gay Becker’s term “recovery potential” was never actually used by any of the therapists interviewed, and it is interesting to note that each therapist had a somewhat different idea of what factors are relevant when deciding what type of therapy to administer on a patient. Becker mentions “the
physical abilities of the patient before the affliction, the ability of the patient to perceive his or her surroundings correctly, the severity of the condition, age, and willingness and ability of the patient to undergo a challenging therapy program (Becker 168). In comparison, one of the therapists mentioned strength and flexibility, cognition (perception of surroundings), sensation, hearing and vision, and medical history as important factors in devising goals for which the patients should strive to reach. Another therapist mentioned strength, endurance, range of motion, bed mobility, and emphasized prior functioning ability as one of the most important factors. The third therapist also emphasized prior physical level of function, saying, “It’s our job to get them back to what they were doing before.” She also listed family support as a crucial factor.

Despite the differences of opinion between the therapists interviewed, all place an important emphasis on the functioning ability of the patient prior to being in the hospital, and stated that the ultimate goal of the therapists was to restore, if possible, the patient back to that level of independence. One therapist stated, “The goal is to get people to fire us. We don’t want to people to get attached to therapy. The goal is to get people to where they don’t need us anymore.”

Conclusion

Based on my observations within a physical therapy department, a number of prominent themes have emerged both from the field itself and from relevant literature on the topic of the therapist/patient interactions. Motivation was seen to be very important for patient participation in rehabilitation, and therapists’ knowledge of the personal aspect of a patient’s life was seen to have been a possible means of motivation, but based on time constraints and heavy workload, was not really emphasized within this particular department. The family support was also seen to have been a crucial factor in patient motivation, and therapists and employees had been observed to propagate the illusion of the curative capabilities of therapy in order to motivate a patient to participate. Furthermore, when establishing goals, prior level of functioning ability was one of the main factors as well, and independence was always the underlying goal.
Works Cited


