A relational exploration of Speech and Language Therapists' perceptions and practice of person-centredness using an Appreciative Inquiry methodology and Socio-Ecological analysis.

Professional Doctorate

Doctor of Health Studies

July 2024

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ABSTRACT

While person-centred care (PCC) is embedded in health discourse and practice, and Speech and Language Therapy (SLT) practitioners plan their professional work with the intention of providing PCC, very little research exists into how SLTs understand and practice PCC in their clinical roles.

80 SLTs across UK SLT adult services participated in a qualitative survey and a further 25 SLTs working in clinical practice in one health board were included in an in-depth qualitative study. The qualitative study used data generation methods of visual inquiry and workshops conducted through the lens of appreciative inquiry. Data collection took place during the Covid-19 pandemic.

Socio-ecological analysis of the conceptualisation, values, practices and professional identity of SLT in relation to PCC in health care surfaced 3 themes: biographical reconstruction, materiality of care and SLT as a social bridge, within an overall theme of relational recovery for patients.

The findings suggest that SLTs enact person-centredness at the intrapersonal and interpersonal levels of the patient’s microsystems through work on communicative identity and swallowing. Also emerging from the analysis is the construction of person-centredness by participants which emphasised the role of relationality, or a focus on patients as individuals situated within a web or network of connections. The analysis also highlights how socio-cultural discourses and practices within healthcare constrain SLTs’ person-centred practice.

The findings suggest that while research can identify the underlying mechanisms of PCC, the context of the pandemic suggests a need to do more to embed PCC as a normal and valued part of SLT practice, and as part of a wider healthcare team. The findings show that more may need to be done, to sensitise health services and SLTs to the potential risks and impacts on the PCC that professionals are able to provide in the context of health service threats.

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Acknowledgements

I am deeply indebted to my supervisors, Professor Sara MacBride-Stewart and Professor Katie Webb, without whose support this thesis would not have been completed. They have guided me throughout this stimulating but immense challenge and consistently encouraged me to ‘find my own voice’ and push the boundaries of my knowledge. I would also like to thank the late Dr Raya Jones for her advice and willingness to share her experience. I appreciate the patience of my family over the many years it’s taken to complete this piece of work. Finally, I am grateful to all the Speech and Language Therapists who willingly gave their time to share their perspectives, thoughts and experiences of person-centredness within their clinical practice.

I dedicate this work to my late parents.

Chapter 1

Introduction and background context

This thesis explores the conceptualisation and application of person-centredness within the clinical practice of a specific group of allied health professionals, namely Speech and Language Therapists (SLTs). This aim is reflected in the thesis title, namely '*A relational exploration of Speech and Language Therapists' perceptions and practice of person-centredness using an Appreciative Inquiry methodology and Socio-Ecological analysis'*. In this introductory chapter I outline the background to the study, information about the profession and practice of SLT, and the context for the research questions proposed.

Background information

Within healthcare work, and medicine in particular, there is recognition that increasing reliance on scientific knowledge has resulted in depersonalisation and a scientistic form of professional practice, with "an accompanying collapse of humanistic values" (Miles and Mezzich 2012, p.207). In both policy and practice there has been a growing move away from the dominant biomedical approach, treating every person with the same disease in the same way, to one that calls for a values-based health service with care based on individual patient values, social context and well-being, and patient involvement. Thus, there is a shift from seeing the person as a 'patient' to a perspective of the patient as a person (Miles and Asbridge 2014).

Simultaneously, health service policy in the UK has highlighted the need for increased collaboration with users of public services (e.g. Department of Health 2010; The Scottish Government 2017; NHS England 2019). The Welsh Government's (2015; 2023) Health and Care Quality Standards identify twelve themes essential to the delivery of a quality health service, all of which work together and are centred on the person. A narrative of person-centred care (PCC) is thus placed at the very heart of service delivery and situated within a quality framework.

Person-centredness is recognised as a key indicator of quality services by the World Health Organisation (WHO 2007; 2015). Person-centredness is synonymous with quality through claims to improve health outcomes for service users and to enrich professional satisfaction for service providers (Health Innovation Network 2012).

McCormack et al. (2017) present an overview of person-centredness on a global level, incorporating North America, Australia, Scandinavia and the devolved countries of the UK in their evaluation. They consider that significant developments are apparent at micro (e.g. practice initiatives), meso (e.g. education) and macro (policy and standards) levels within the previous 10 years. However, they express concern that there remains a gap between what patients experience and the “strategic rhetoric of person-centredness” (p.7).

My study is concerned with the understanding and application of the concept of person-centredness within SLT clinical practice within services for adults, as explained below. In the justification for my study, I outline the different types of clinical roles undertaken by SLTs and how the profession is regulated and overseen professionally.

Information about the profession of Speech and Language Therapy

Each health profession is subject to regulatory control and adherence to professional standards by its regulatory and professional bodies. SLT is regulated by the UK-wide Health and Care Professions Council (HCPC) and its professional body is the Royal College of Speech and Language Therapists (RCSLT).

Speech and Language Therapy is one of the Allied Health Professions, others being Dietetics, Occupational Therapy, Physiotherapy and Podiatry. In line with the other therapy professions, an undergraduate degree in Speech and Language Therapy, in addition to a licence to practise from RCSLT, is required for employment as a SLT within the UK (or worldwide). The title ‘Speech and Language Therapist’ is a designated title (within the UK) protected by legislation, and in order to use this title to practise clinically within the UK, the individual must be registered with HCPC (HCPC 2020).

SLT practice is composed of relationships: clinical (with patients and colleagues); organisational (with the employing organisation); regulatory/professional (with HCPC and RCSLT) and political (each devolved government of the UK). Health services in Wales are the responsibility of the Welsh Government (WG). The WG’s health policy is then translated by each individual health board into their own strategic vision, mission statement and operational mandate to achieve these goals (Welsh Government 2021). SLT practice is therefore governed by a complex and wide-ranging framework, involving relationships between the different elements of political, organisational, professional and regulatory domains. These govern SLT practice in all services including individual SLTs. These relationships are illustrated in Figure 2, Chapter 2.

1.1.2 The role of SLT

SLTs work with both children and adults who have communication and swallowing problems. HCPC (2020) describes the role as:

> A speech and language therapist assesses, treats and helps to prevent speech, language and swallowing difficulties.

RCSLT's website informs viewers that:

> Speech and language therapy provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing.
>
> Speech and language therapists work together with children, adults, families, carers and the wider workforce, to carry out assessments and plan personalised therapy programmes which meet each individual's communication and swallowing needs. They work in a wide variety of contexts and environments including:
>
> ☛ community health centres
>
> ☛ hospital wards and intensive care units
>
> ☛ outpatient departments
>
> ☛ children's centres, mainstream and special schools
>
> ☛ assessment units, day centres and nursing homes
>
> ☛ clients' homes
>
> ☛ courtrooms, prisons and young offenders' institution.
>
> (RCSLT 2020)

The information illustrates the wide-ranging roles of SLTs and the different situations in which they may work. The following section describes the types of communication and swallowing disorders treated by SLTs in adult services across all these contexts.

1.1.2.1 Information about acquired communication and swallowing disorders.

Acquired communication difficulties (as opposed to developmental communication difficulties and learning disability) treated by SLTs working in adult services arise from multiple causes: stroke, acquired brain injury, progressive neurological diseases such as Motor Neurone Disease or Parkinson's Disease; mental health; dementia; stammering; voice problems, including voice changes associated with transgender transitioning and patients who have undergone surgery such as laryngectomy as part of treatment for head and neck cancer. Except for voice, these diseases manifest themselves as communication difficulties in problems with speech, language and / or cognition or a combination of both. The aim of SLT intervention in communication work is to enable the patient to engage in and negotiate everyday life and maintain, foster or reconstruct relationships, whether they be with family, friends or wider within the patient's community.

Many of the medical conditions which cause communication difficulties also result in problems with swallowing. Assessment and remediation of swallowing difficulties (dysphagia[1]) are also a part of SLTs' remit. SLTs' dual roles, with responsibility for assessment and remediation of both communication and swallowing problems, are fundamental to the social functioning of patients i.e. SLTs "enable better lives" (RCSLT 2019, p.9) by supporting patients to interact, socialize and eat, meeting the basic conditions of everyday life.

1.2 Origins, aims and outline of the research.

1.2.1 Biography of the research question

My SLT career began in 1991, and apart from three years initially when I worked within both adult and paediatric SLT services simultaneously, my whole career has been spent within adult SLT. Over time I specialised clinically in acquired brain injury, particularly the complex sequelae of traumatic (a direct insult to the brain from physical trauma) or non-traumatic brain injuries, such as hypoxia (lack of oxygen), or infection such as meningitis or encephalitis. The consequences of such injuries often result in both cognitive-communication disorders and swallowing difficulties.

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[1] Dysphagia is the medical term for difficulty in swallowing. It occurs when there is a problem with the neural control, or the structures involved in any part of the swallowing process.

My work within a regional, tertiary neurological rehabilitation setting always involved working with the patient and their family. The importance of the patient's relationships within rehabilitation and healthcare work generally has always been evident to me but this was not reflected formally in either professional guidelines or organisational directives at the time. It is only in later years and particularly following more empirical research into person-centred clinical practices, that the importance of the patient as a person within their own networks gained credence (see Dahlberg et al. 2009; Pound 2011). Aligning with this is the change in focus within SLT clinical work from impairment-based therapy to one that embraces the patient as a social being within family and community (e.g. Douglas 2015; Azios et al. 2022).

As my career progressed, I undertook more management duties and eventually became the Service Lead for an SLT adult service, a service which covers tertiary acute wards, rehabilitation settings, and community. The service strives to be person-centred and this led to my curiosity as to how staff understood and perceived person-centredness in their daily work, with the ultimate aim of service improvement. The study is therefore personally, professionally and politically pertinent.

1.2.2 Aims and process

This thesis started in early 2109, where my clinical SLT background generated an interest in the professional practice of SLTs and key strategies they used to implement PCC. My initial ideas were largely uninformed by the academic literature, but were based on my understanding of how healthcare professionals were expected to act within the NHS. I had previously completed a Master's in Professional Development and struggled to find evidence from research to provide insights or support for my belief that SLTs have a key role in providing PCC. I set out to explore these questions as part of my Professional Doctorate.

Taking a predominantly iterative approach, the first part of the process was a literature review aimed at understanding the nature of PCC from a healthcare and SLT perspective. The methodology of Appreciative Inquiry was then decided upon, in the context of Covid-19, followed by the ethics process as explained in the methodology chapter.

Data collection was commenced, the different phases of which are explained in pages 49-53. Emerging reflections on the data and discussion within supervision led to recognition that a deeper theoretical perspective was needed, hence thinking around the Socio-Ecological Model (SEM) was developed. Indeed, my progress reviewer advised that the SEM could not only be a tool for analysis but could help to situate my ideas more clearly by becoming a key part of the literature review; this was then added to the second part of the literature review. The final thesis structure therefore does not completely reflect the order of my thinking throughout the research process.

All the findings are collated in the four analysis chapters, with the impact of Covid-19 on the data also included. The final chapter integrates reflections on the aims and interpretations of the findings.

1.2.3. Thesis outline

Chapter two presents a literature review into the conceptualisations of person-centredness in healthcare and explores how a socio-ecological model (SEM) within qualitative healthcare research can provide a specific lens for analysis. The impact of Covid-19 on person-centredness in practice is also considered. In Chapter 3 I situate my study methodologically and discuss the research design and its conduct. Chapters 4-7 outline the findings from the research and analysis of these in the context of the literature and through the lens of SEM, elements of systems thinking and Covid-19. Conclusions to the research are presented in Chapter 8.

Chapter 2: Literature Review

Overview of chapter

In Chapter 1 I outlined the justification to the study and clarified the process. The questions initially informing the literature review were a) how do SLTs understand the concept of PCC; b) what are the values and practices underpinning this understanding; c) how is PCC understood within healthcare. As the literature review progressed, further questions related to Covid-19 and the socio-ecological model were added (see chapter summary for final research questions).

The first part of this second chapter highlights how person-centredness is relationally constructed; it is concerned with the personhood of both patients and healthcare practitioners (HCPs) and is closely aligned with development of a person-centred culture within the workplace. The implications for HCPs and SLTs to work in a person-centred way are discussed, as are critiques of this approach to healthcare delivery.

The second part of the chapter reviews the impact of Covid-19 on person-centredness within healthcare and how the pandemic, with changes in practice related, for example, to infection prevention and control procedures, affected person-centredness in daily practice. The pandemic also highlighted how relationality is a key element of person-centredness (see Edvardsson et al. 2020).

The final section considers how the socio-ecological model (SEM), based on models adapted from Bronfenbrenner's original (1979) model, has been utilised in qualitative research on healthcare. Use of such a model allows illumination of the multiple levels which exist within a complex system such as healthcare, and illustrates how all levels impact on, interact with and influence each other. The model also shifts us to talking about healthcare as a set of relationships through which different explanations of PCC could be considered. Literature relating to SLT practice in connection with the above fields of PCC, Covid-19 and SEM are also discussed.

2.1 Method of literature search

Feldthusen et al. (2022) and Forsgren et al. (2023) highlight the challenges in screening the literature concerned with centredness in healthcare. These difficulties relate to a) the numerous terms that are used, for example patient-, person-, family-or relationship- centred care; b) other fields of research such as shared decision making or narrative medicine overlap with centredness; and c) the existence of only one Medical Subject heading (MeSH), namely patient-centred care. Forsgren et al. (2023) indicate that a thorough search in major databases results in greater than 90,000 citations and advocate the use of text-mining software for ease of searching.

Due to the above challenges, I adopted a pragmatic approach by limiting the databases searched (Scopus, Medline, Web of Science and ASSIA) and restricting the time period to 2010-2024. Due to high numbers retrieved, I restricted the time period further to 2014-2024.The search terms are presented in Appendix 1. I also searched Google Scholar and undertook the checking of references of key publications and citation tracking; relevant journals from the journal library of RCSLT were also reviewed. Many publications included in the review were obtained in this way. Abstracts were screened for adult population, and references included if they pertained to broader aspects of PCC such as conceptualisation and working with the patient and their family or the application of PCC in SLT clinical practice. Papers relating to specific aspects such as goal-setting or shared decision-making were excluded. Published research on PCC in relation to Covid-19 and SEM were also included.

2.1.1 Results of literature search

Figure 1 shows the results of the literature search, with 70 papers included in the final review.

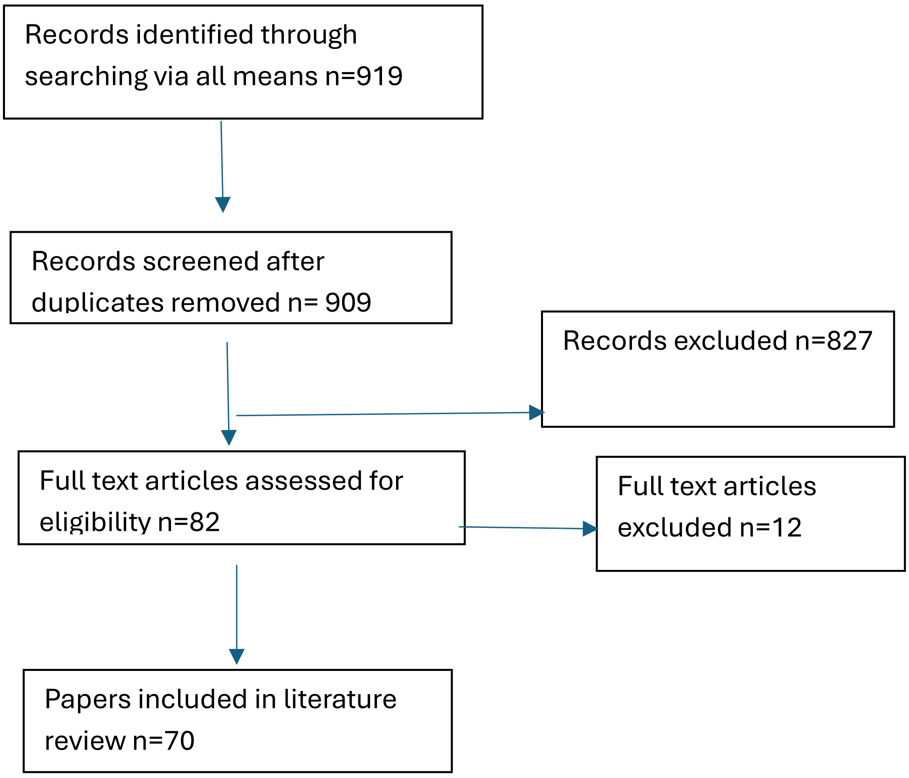

Figure 1: results of literature search.

2.2 Concepts in PCC

This chapter considers the terms and concepts associated with the humanistic approach of centring healthcare around patients and their families. These terms comprise personhood, person- or patient-centred care, and person-centred culture. The concept of being a 'person' underpins centredness and different theoretical perspectives result in variation in the application of this concept in practice (see Edgar et al. 2020; McCormack et al. 2021).

The argument that I make in this section is that although patient- and person-centredness are often used interchangeably in the health literature, researchers in the field e.g. Buetow (2016); Zhao et al. (2016) stress the differences between these two labels at both concept and practice levels. In this chapter I will clarify the nuances and tensions between them, review how these terms are used in the literature and the challenges inherent in their operationalisation in practice.

2.3 What is centred care?

Centred care is care centred on the person (Institute of Medicine 2001; WHO 2007). Reviews of centredness in healthcare are offered by Feldthusen et al. (2022) and Sturgiss et al. (2022). Both publications aim to clarify the core elements while Sturgiss et al. also consider the healthcare context in which centredness is conceptualised. The search strategy for both reviews do not differentiate between patient- and person-centredness.

Feldthusen et al.'s (2022) review focused on the wide-ranging scope of centredness and not solely on specific aspects such as shared decision-making. Three main themes are generated: attributes of centredness (being unique, being heard and shared responsibility); how centredness is done in practice (through interaction between the patient / family and the HCP); and evaluation of outcomes of centredness. The first theme reflects mainly the views of patients while the second theme echoes the reflections of HCPs.

According to Feldthusen et al. (2022), translating the theory of centredness into practice is predicated on actions such as getting to know the patient well, especially their life story, social context, and relationships. Active listening and building trust are highlighted as essential for this process. The authors note that several pre-requisites are required to support centred practice: an organisational culture recognising the personhood of the HCP and patient; training of HCPs in communication skills and cultural sensitivity; time to build relationships with the patient; flexibility of service processes and policies; and person-centred documentation and guidelines.

Feldthusen et al.'s (2022) aim of evaluating the effects of centred care proved challenging due to varied and disparate outcomes recorded in the literature reviewed. However, they note that outcomes directly affecting patients' life participation are rarely recorded and observations often relate to biomedical outcome measures valued by HCPs.

Sturgiss et al. (2022) regard centredness as a multidimensional concept, which is "not linear, static and simple" (p.2), one that operates at different levels of the healthcare system, from individuals (patients) to organisational and beyond. This review's nine core elements align with other explorations into centredness, with the three most common elements being shared responsibility for care, conceiving the patient as a person and building the therapeutic relationship.

The authors note that most papers reviewed originated from a Western perspective, valuing patient autonomy and individuality. The publications describing a non-Western approach to practice (e.g. Maori), retained similar core elements but brought these together in a different way. There was greater emphasis on seeing the person "as part of a collective […] seeing people as part of their family, community or wider society" (p.5), which is consistent with Te Ao Maori or a Maori way of perceiving and understanding the world.

2.3.1 'Patient' versus 'person' centredness

Within the health literature the two terms of patient- and person-centredness are still used interchangeably, although Buetow (2016), Zhao et al. (2016) and Håkansson Eklund et al. (2019) have attempted to differentiate and compare the two models. Buetow (2016) distinguishes PCC from its patient-centred counterpart by its recognition of the personhood of the clinician. He asserts that patients and HCPs are moral equals and that a true person-centred approach connects the "equal moral interests of patients and clinicians, as persons… to balance and maximise their joint welfare" (p.110). Patient-centredness is critiqued by Buetow (2016) for its primary focus on the patient, to the detriment of the personhood and welfare of the clinician, which serves to undermine the interrelatedness of the relationship. It is also critiqued for its roots in evidence-based medicine with its reductionist and standardising approach to care.

Zhao et al. (2016) differentiate between patient- and person-centredness at a conceptual level and suggest that they diverge not only at the object of care, but also at the level of the main decision-maker. These authors state that person-centredness emphasises health promotion and orientates itself around the person's social context whilst viewing "episodes as part of life-course experiences with health" (p.400). In contrast, patient-centredness is rooted in a process based on biomedical treatment of disease, with their analysis therefore focusing largely on (unequal) relationships within the healthcare system.

Edgar et al. (2020) consider patient-centred care to be concerned solely with the patient and family to the exclusion of the HCP's wellbeing or personhood. They assert that this model of centredness has a biomedical and disease-management focus even though it includes consideration of the patient's preferences and values.

In contrast, Waters and Buchanan's (2017) scoping review explores person-centred concepts across human service delivery contexts, identifying seven core themes aligned with person-centredness. The first theme was seeing the patient as a person, respecting individuality and getting to know them well to understand their life experiences, values and beliefs.

Another main theme was linked to the patient's relationships and working with their significant others, including building the therapeutic relationship between patient and HCP. Social inclusion in meaningful activities within their local community was associated with person-centred intervention. Other themes concerned working with the patient's strengths, facilitating personhood and humanity through compassion and hope, while organisational culture underpinned and facilitated staff to work in person-centred ways. Here, person-centredness is more closely aligned to Sturgiss et al.'s (2022) conceptualisation of centred care as a multidimensional concept.

A meta synthesis comparing but also integrating the two concepts of patient- and person-centredness is presented by Håkansson Eklund et al. (2019). Of the total 13 themes generated, nine were common across both concepts, although the authors posit that the goals of the two approaches appear to differ. Patient-centred care, they suggest, is concerned with facilitating a functional life for the patient, while the goal of a person-centred approach is a meaningful life. In line with this, further analysis also revealed subtle differences in three of the nine common themes: empathy, communication and holistic care. In patient-centred care, empathy is conceived as recognition of the patient's feelings, while person-centredness extends this recognition to the person's whole life context and is not confined to feelings apparent solely in the moment. Person-centredness views communication as integral to obtaining the patient's narrative and not merely for sharing information as in patient-centred care.

Finally, holistic care as a part of person-centredness emphasises the interdependence and importance of considering all aspects of the patient as a person i.e. spirituality, cultural and social context, physical and biological dimensions (see Loughlin 2020;

McCormack et al. 2021) whereas within patient-centred care the psychological and social factors are often additions. So, by closely analysing the two concepts using a multidimensional approach Håkansson Eklund et al. (2019) show how patient-centred care is actioned more for the benefit of the HCP whereas person-centred care seems more concerned with understanding the needs and processes of meaning-making for the person within their own context over the life course.

2.4 Why is person-centredness important?

Miles and Asbridge (2023) provide an overview of how and why PCC has become so prominent in medicine and healthcare in general. They ascribe the rise of PCC partly to the increase of chronic illness in society, with its concomitant multiple co-morbidities, necessitating a different model of healthcare from acute biomedical care. Chronic illness is not confined to an acute episode of ill-health and requires a model of care over the patient's life course. A biomedical approach to care does not address patients' psychological, social and emotional needs that frequently accompany chronic illness, but often focuses on single disease.

In discussing the limitations of scientific medicine, the authors suggest that PCC can address the myriad worries and issues that concern patients. People who are unwell present as:

> Integral human beings with narratives, values, preferences, psychology and emotionality, cultural situation, spiritual and existential concerns, possible difficulties with sexual, relational, social and work functioning, possible alcohol and substance abuses and addictions, worries, anxieties, fears, hopes and ambitions, personal life goals and aspirations—and much more.
>
> (Miles 2015, p.985).

In effect, health cannot be considered or understood as an isolated component of the patient's life but needs to be integrated with every element which affects wellbeing (Loughlin 2020).

Miles and Asbridge (2023) propose three additional justifications for a person-centred model of practice:

- ethical grounds.
- evidence-based justification (due to PCC's growing empirical research base in addition to qualitative literature).
- economic justification (the PCC literature demonstrates this model of care can result in changes in patient behaviour of reduced utilisation of healthcare services due to increase in patient self-management, with subsequent reduced costs).

Each of these could be considered key elements in integrating the necessary relationships for PCC within and external to health care. Ethical grounds include the argument of placing the person's needs within their own context and relationships; empirical research suggests that person-centred approaches to care achieve better outcomes (Gordon 2020; Mitchell et al. 2022) with often reduced costs (Hansson et al. 2015; Wildevuur and Simonse 2015).

2.5 Personhood and Self

Two of the main ideas so far in this chapter are the importance of relationships, and consideration of an individual's personhood in the concept of PCC. In this section I discuss the literature that considers the latter, as not all literature defines the concept of person or personhood, and understanding can differ widely.

Central to person-centredness is the health professional's ontology of what being a person means, and Anker-Hansen et al. (2020) assert that person-centredness is "the operationalising of personhood" (p.130). McCormack et al. (2021) and Edgar et al. (2020) provide reviews of different philosophical approaches to personhood. Edgar et al. (2020) condense these different approaches: e.g. philosophical perspectives like Kant's view of all persons having "equal worth and value" (p.3); Post's (2013) physicalist view based on intact cognitive or functional abilities, the more common being autonomy and rationality (drawing on Kitwood 1997). Edgar et al. suggest views based on cultural or spiritual perspectives may become prominent towards the end of life (drawing on Chochinov and Cann 2005; Post 2013).

McCormack et al. (2021) embrace Leibing's (2008) argument that "personhood is that inner feeling we have that guides us as a person" (p.7) based on our values and wishes. Leibing links this inner feeling with what really matters to us, which ultimately affects and inspires us (termed ‘interiority’ by Leibing (2008)). However, Leibing also notes that diseases such as dementia may compress or even crush this interiority so that person’s full personhood is not realised within medical processes.

McCormack et al. (2021) note the importance of Smith’s (2003) work on moral codes by which human persons live their lives. This moral code (based on our core values and beliefs and societal influences and cultures) operates in conjunction with ‘interiority’ in shaping our actions. This ‘shaping’ is constant and unremitting thus personhood is “not a static fixed concept but something that is continuously evolving and developing” (p.8). Thus, workplace culture in healthcare settings assumes an equal importance to staff values in affecting staff behaviours.

McCormack et al. (2021) draw on the work of Sabat (2002), who proposes three forms of self. ‘Self 1’ is autobiographical and uses language to relate to the world. ‘Self 2’ constitutes cognitive and physical attributes while ‘Self 3’ is socially constructed and varies according to the situation in which a person finds themselves i.e. they present a different person to the world depending on the social situation.

The main difference between these three selves is in response to illness or disease. Sabat (2002) argues that ‘Self 1’ and 2 remain generally intact despite disease processes, even those resulting in loss of language. However, facilitating a person to tell their story when their communication skills are affected can be challenging. ‘Self 3’, due to dependency on social interaction, is most at risk, not only in illness and disease, but also in healthcare practices where the social understanding and autobiography of the illness is disregarded. ‘Self 1’ and 2 therefore become even more important in safeguarding personhood, although the ways in which healthcare practitioners view ‘Self 2’ can influence a patient’s personhood. For example, a focus on deficits and impairments rather than on strengths and abilities can diminish ‘Self 2’. McCormack et al. (2021) link Sabat’s work on self to Merleau-Ponty’s (1989) argument that mind and body cannot be separated, and that the physical body is our means of engagement with the world. Care and respect for the physical body therefore equates to respect for personhood as ‘Self 1’ is always there.

In their review Edgar et al. (2020) remind us how perspectives differ greatly according to culture. Western cultures value individuality and autonomy, while non-Western approaches place the person within their communities, connected to specific cultural and social practices. This affects how personhood is understood and operationalised with implications for understandings of PCC in healthcare. Indeed, Phelan et al. (2020), in their review of person-centredness' position in healthcare policy worldwide, note that person-centredness is positioned globally mainly within a Western philosophical framework. This Western framework reduces PCC to individual and interpersonal relationships rather than a wider set of relationships that are relevant to discourse, culture and power.

Like non-Western perspectives, feminist researchers approach personhood as a fluid and relational concept, where people's relationships and networks influence and sustain individuals to live their best lives (see Dionne and Ells' (2022) review of feminist contributions to PCC). The person as a relational being[2] is core to feminist conceptions of personhood. Another core contribution by feminist researchers is the idea of the self as transformed by illness and life experiences and undergoing what Dionne and Ells (2022) call "the continuous process of personal becoming" (p.380), contradicting the notion of the self as a static being throughout life. For patients in healthcare contexts, from a feminist perspective, people are always "in-the-making" and the process of 'becoming' is never complete, meaning that even receiving a diagnosis is not a static moment in a patient's life. Interactions with healthcare professionals and their practices contribute to this process as they shape and influence the patient (Dionne and Ells 2022).

Personhood therefore underpins PCC and affects its operationalisation in clinical contexts according to the HCP's understanding of the concept. I approach personhood from a feminist perspective as this account of personhood expands the potential of the concept of PCC by allowing a more critical account of a person as dynamic and not static over the life course.

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[2] May and Nordqvist (2019, p. 186): As social beings, much of what we do is in connection with other people and much of what we understand is derived from relationships with other people.

2.6 Person-centred care - problems of definition

Dewing and McCormack (2016) acknowledge a lack of consensus in the literature regarding how PCC is defined, noting it is common practice to define person-centredness solely by one or more of its attributes, such as shared decision-making with the patient. This, they argue, serves to over-simplify the concept.

Waters and Buchanan (2017) suggest that PCC is problematic to define and assert that previous definitions have been confined to specific clinical areas, such as learning disability, mental health and dementia. They propose that there is little evidence of shared understanding at a conceptual level across clinical siloes, which is particularly concerning since much of healthcare is delivered across settings and diagnostic groups. These authors state that clinical context determines the definition or meaning of PCC, a view supported by El-Alti et al. (2019). Edgar et al. (2020) also note how a discipline-specific approach to the theory underpinning person-centredness within healthcare may be a barrier to its progression across organisations and call for interdisciplinary scholastic endeavour.

Harding et al. (2015) consider PCC to be both a process and an outcome. Conceptually, three pillars are recognised, emphasising support from the health professional, combined with exchange of information, negotiation and discussion between patient and clinician (Table 1):

Table 1: the 3 pillars of PCC (Harding et al. 2015, p. 3).

Pillar 1	A group of parameters such as shared decision-making, communication and co-production between the person and the healthcare provider. Promotion of self-management is also a component of this pillar.
Pillar 2	Personhood: recognition of the patient as a distinct individual within their own social context.
Pillar 3	Partnership, with trust and mutuality as key elements. The therapeutic relationship (the working relationship between patient and HCP) therefore underpins this pillar.

The World Health Organisation's (2016) definition of PCC adopts a people-centred language, where the 'person' can be an individual, family or community:

> ‘...an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways… It is organised around the health needs and expectations of people rather than diseases.
>
> (World Health Organisation, 2016, p.2)

This definition emphasises not only the humanistic approach i.e. sees them as participants but also recognises the relationality (participants as well as beneficiaries) inherent in person-centred ways of working; the individual is recognised as part of a family and community; they are also part of the system of responses made by health systems, as well as the relation between what people need and what health systems can offer. This relationality is highlighted by Phelan et al. (2020) who state PCC involves:

> Consideration of humans as persons, situated in their own lived culture, time, places and relationships. In this context, person-centredness is relational.
>
> (Phelan et al. 2020, p.3)

As highlighted in section 2.5, feminist conceptions of PCC are underpinned by a relational ontology, acknowledging how social relationships and contexts (cultures/ places described above) shape and influence a person’s values, beliefs and choices. Dionne and Ells (2022) stress that HCPs need to consider this relationality more explicitly when planning interventions by including family members or others important to the patient. That adds to the WHO idea of relationality, as an ongoing process across the life course. The idea of the person as an atomistic individual is rejected by feminist scholars and instead the notion of relational autonomy is proposed, as it is within social and cultural relationships, and over time (see Phelan et al. above) that people develop abilities and competence, such as communication skills and self-confidence, necessary for autonomy.

Problems with definition include geography (Miles and Asbridge 2023) and different applications in different clinical contexts (Mitchell et al. 2022). These latter authors contribute to the argument regarding definitions of PCC by considering the positives and negatives of achieving a ‘standard’ definition for operationalising it within healthcare contexts. Whilst technical definitions are advantageous in helping to operationalise and then measure a concept, in addition to aiding practice development, they also argue that "vagueness is [not] inherently problematic" (p.10) "but also that it tolerates multiple accounts of person-centredness" (p.11). The authors argue against the universal applicability of a fixed definition of PCC as the person and the context should determine which aspect or dimension is highlighted.

2.7 Person-centred culture

So far in this chapter I have reviewed the conceptualisation of centredness in healthcare and differentiated between patient- and person-centredness. I have also explored the concept of personhood which the literature argues underpins the operationalisation of person-centredness. This section now turns to person-centred culture i.e. one where the personhood of all stakeholders is considered and which Buetow (2016) and McCormack and McCance (2017) regard as an essential pre-requisite for person-centred healthcare.

McCormack and McCance (2017) emphasise that person-centredness is predicated on first developing a person-centred culture in the workplace:

> Person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.
>
> (McCormack and McCance 2017, p.3)

McCance and McCormack (2023) regard healthful cultures as the result of person-centred cultures, defining healthful cultures as "contexts that are energy giving for the benefit of health and wellbeing" (p.1) which includes all persons concerned. They argue that if HCPs are uplifted by their work context, then that enthusiasm should "connect with the personhood of all persons". This will ultimately allow everyone (HCPs and patients) to flourish, proposing that "the ultimate manifestation of person-centredness is 'flourishing persons'" (McCormack et al. 2021, p.42).

In their discussion on human flourishing, the authors draw on Seligman's (2011) work on psychological wellness, particularly the PERMA model (**P**ositive emotions, **E**ngagement, **R**elationships, **M**eaning and **A**ccomplishments). While acknowledging the usefulness of this model, McCormack et al. (2021) note the importance of context, especially workplace cultures which enable staff to be fully engaged, foster positive relationships, promote staff learning and development and value the personhood of staff.

To enable a person-centred culture, a practice recognising the personhood of all involved is first required; this includes all individuals in the provision of healthcare (Buetow 2016). Phelan et al. (2020, p.4) note this type of approach incorporates other essential concepts such as flourishing, leadership, and inter-professional collaborations which allow person-centredness to develop. Edgar et al. (2020) term this more inclusive practice as person-centred *practice,* in contrast to person-centred *care* which, they assert, recognises only the patient's personhood.

The pre-requisites for the creation of person-centred cultures are identified by McCormack et al. (2021) at all levels of the healthcare system (micro, meso and macro). Policy frameworks at a macro level need to be translated into strategic leadership and organisational goals, which are then underpinned by staff personal and professional values, professional skills and supportive interprofessional relationships. This is discussed further in the next section of this chapter.

2.8 Implementation in SLT

The evolution to a person-centred culture and a more healthful or humanistic practice calls for a change of mindset for all health professionals, including SLTs. The challenge of changing approach to healthcare is not underestimated by McCormack et al. (2017). The changes required span organisational processes, inter-professional relationships and HCPs' skills in building and maintaining equal, trusting relationships with their patients, at the core of which is "a deeply held, values-based commitment to persons and personhood" (Phelan et al. 2020, p.3).

To facilitate and support person-centredness, McCance and McCormack (2023) note the need for a social model of healthcare which, they argue, takes account of "the body… as being bound up in and emerging from many different relationships involving biological, social, psychological, cultural and individual processes" (Yuill et al. 2010, p.12). There is recognition of the myriad influences on health and the complex inter-play of many different elements.

Miles and Asbridge (2023) call for PCC to be embedded within regulatory and ethical guidelines, which would render PCC “integral to clinical professionalism” (p.698). This, they propose, would ensure that professionalism is not based solely on what they term “legally acceptable, regulator-satisfying, basic technoscientific competence” (p.698) but incorporates person-centredness so that clinical practice is of the highest standard possible.

2.8.1 The challenges of implementation

In the context of these debates and clarifications, PCC has emerged as a central discourse and practice in healthcare, but implementation is not without its challenges; despite these, the work on PCC has emerged as a set of frameworks, approaches and principles.

Harding et al. (2015) consider certain ‘tools’ to be key to enabling this approach. These tools cover workplace culture and peer behaviour; education and training of the workforce, especially in communication skills involved in shared decision–making - this reflects the importance of the interpersonal relationship emphasised by Naldemirci et al. (2018). Further tools advocated by Harding et al. (2015) include promotion of values-based reflective practice, techniques for active listening and effective communication to support self-management, shared decision-making and goal setting.

Frameworks which claim to enable person-centred practice have been developed within defined clinical specialties. For example, within services for older people, the Senses Framework (Nolan et al. 2006), is an approach based around relationships. Another model developed by the University of Gothenburg Centre for PCC (GPCC) is claimed (Ekman et al. 2011) to be an evidence-based approach to PCC. It is based on three routines, all of which act to build, maintain and record the partnership between health professional and patient, the routines being elicitation of the person’s narrative, use of this narrative to discuss and agree goals, and documentation of the narrative and proposed goals. Buetow (2016) however, critiques the GPCC model, stating that it “re-dresses patient-centred health care in new linguistic clothes” (p.108), since patient-centred care already recognises the patient as a whole person.

Tyerman (2018) concurs with the importance of the patient's narrative, and states that it is essentially the 'starting point' of clinical practice:

> We need to re-establish narrative at the centre of healthcare…it is through narrative that, as healthcare providers, we focus on the whole organic person rather than on the mechanisms operating within the body.
>
> (Tyerman 2018, p.2)

This approach focuses healthcare's attention on all elements of the patient's life which affect their wellbeing and brings to the fore the patient's personhood and experience of illness, emphasising their social context and relationships.

The challenges involved in enabling persons with communication difficulties to provide their narrative are considered by Naldemirci et al. (2018). They call for a broader definition of the patient narrative so that narratives constructed jointly with family members or those elicited using means such as visual aids are recognised as valid. This resonates particularly for SLTs who regularly facilitate alternative means of communication with their patients.

McCormack and McCance's (2017) Person-Centred Practice Framework (P-CPF) covers four healthcare levels, all situated within a fifth (macro) level. The authors claim it is appropriate for all health professionals to use and that the model 'illuminates practice' through its inter-related domains, comprised of pre-requisites (staff attributes); practice environment (people, processes and structures); person-centred processes (ways of working holistically) and person-centred outcomes (healthful cultures and human flourishing) (see McCormack et al. 2021). The P-CPF therefore not only acknowledges different levels and elements which interact and influence each other but acts as both a process and an outcome.

Feminist scholarship (Dionne and Ells 2022) offers conceptual tools to aid implementation of person-centredness, drawing on the previously explained feminist idea that PCC is about relationality and fluidity. These 'tools' are predicated on the idea of "altered selves and the continuous process of personal becoming" (p.380) and require a change in "knowledge and caring practices" (p.384). These 'new' healthcare practices need to recognise the patient's embodiment and how they make sense of their "lived experiences with ill health" (p.384) i.e., how illness and disease may shape multiple selves over time, especially as physical changes progress, or the body deteriorates. This process, they argue, is the “ongoing and relational process of being and becoming a person” (p.380), which continues to be shaped during each healthcare encounter. HCPs need to consider how their practice contributes to this shaping and take account of each patient’s relationality. HCPs must develop communication skills and an approach that allows the person to explore “new life goals, values and identities” (p.385).

McCance and McCormack (2023) note the need for a shared language to enable changes within healthcare systems. This shared language needs to clarify what person-centredness is, to achieve understanding across all stakeholders, from policy level downwards. In this way person-centred cultures can be developed.

2.9 Critiques of PCC

This section considers current critiques of PCC, particularly regarding identity over the life course; political or economic associations of PCC and finally, critiques of stand-alone ‘tools’ often considered to capture PCC in its entirety.

Feminist scholars present a critique of current interpretations of PCC based on its interpretation of the person as static throughout the life course (Dionne and Ells 2022). Central to feminist posthumanism is the concept of the person as constantly ‘in the making’, with new experiences, including those of illness and disease, relationships and encounters helping to co-create the person, ideas alluded to earlier in the chapter. In this way the person’s identity, values and life goals can change and evolve. This contrasts with current neo-liberal ideology which frames PCC and presents the person as static, with biographical continuity. New encounters which shape people include those with health care professionals and the implication is for practitioners to recognise the relationality brought to the interaction and how they themselves influence that encounter.

Byrne’s (2022) doctoral thesis offers a critique of PCC where she suggests that PCC is a ‘technology of compliance’, especially in the management of patients with chronic conditions. Byrne argues the goals of patient self-management are in part associated with protecting the scarce resources of healthcare but also include a value judgement whereby a person with chronic disease will want to undertake self-care. This directly contrasts with Miles and Ashbridge's (2023) assertion of the economic benefits of PCC which they present as a positive factor.

Cribb and Gewirtz (2012) also critique shared decision-making and increased patient agency, arguing that this increased agency requires a "remaking of moral identities" (p.508) by professionals and service users, and that ethical complications are often simplified or ignored. Thus, the benefits of increased agency are often promoted to the detriment of any inherent ethical tensions, as "discourses around user involvement are frequently one-dimensional" (p.508).

2.10 Emerging perspectives on SLT practice as PCC

Although the literature base considering the understanding and implementation of person-centredness by SLTs is slowly growing, there is a need for more research into how SLTs enact person-centredness (Forsgren et al. 2022). These authors provide a scoping review of person-centredness in SLT practice and research; this review covers adult services only and does not include the views of patients.

The authors' aim was to uncover the volume and content of relevant literature; how PCC is understood by SLTs and the theoretical frameworks underpinning it; and to explore publications connected to the GPCC's three routines for PCC (described in section 2.8.1). The 134 papers reviewed included discussion papers; guidelines as to how SLTs could work in a person-centred way, especially relating to certain clinical categories, and publications investigating aspects of PCC such as patient narratives.

The review unearthed that SLTs view PCC as a means of supporting patients to live 'better lives', and that SLTs consider the patient's everyday life when planning intervention, consistent with the WHO's International Classification of Functioning, Disability, and Health (ICF) framework (WHO 2001), related to a biopsychosocial approach. However, Forsgren et al.'s review also uncovered publications calling for SLTs to 'flip approach' and start at the end i.e. concentrate on the person's strengths, values, wishes and social context before attempting assessment of deficits or impairments (see Cruice 2008; Hinckley 2016; Khayum and Rogalski 2018). Another approach utilised by SLTs working in the field of aphasia[3] is the Life Participation Approach to Aphasia (LPAA) (Chapey et al. 2000) which centres on the patient's everyday life participation and which Rogalski and Khayum (2018) align with person-centredness. In contrast, other publications highlighted in the review consider that life participation is not explored sufficiently during SLT intervention (see Torrence et al. 2016).

Elicitation of patient narratives, through verbal or picture-based means, is highlighted in the SLT literature reviewed, although knowledge and skill of the communication partner is regarded as essential. Indeed, Forsgren et al. (2022) state that "Speech-language therapists play an important role as effective communication is at the heart of PCC" (p.398), as facilitation of patient narratives help to educate other members of the MDT as to the patient's values and wishes for care.

Partnership between the patient and SLT is underlined in the review, particularly when SLTs reveal something of their own personhood within this therapeutic alliance. This relationship also extends to the patient's family. Another feature of this partnership concerns shared decision-making and goal setting, where the literature reviewed is mixed regarding how much patients actively participate in this process, particularly if their communication is severely compromised. Specific tools such as Talking Mats[4] (TM) (Murphy 1998) help promote a person-centred approach to goal setting and are alluded to in the literature, although actual use may be limited (Berg et al. 2017). Forsgren et al. note potential barriers to PCC posed by how communication goals are documented; health record systems as an organisational barrier are highlighted by Heckemann et al. (2020). Current health records often reduce the 'person' to signs and symptoms and document biomedical goals to the detriment of the patient's life-world goals (Lydahl et al. 2022). Forsgren et al. conclude that most of the literature reviewed related to *how* SLTs can work in person-centred ways and call for more research into whether this occurs in practice.

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[3] Aphasia: is a language disorder caused by damage to the areas of the brain controlling language expression and comprehension. A person with aphasia may have problems understanding spoken language, speaking, reading or writing.

[4] Talking Mats is a picture-based communication tool which supports people to share their thoughts and feelings by thinking about a topic in a concrete, structured way.

Published literature regarding practice within designated clinical fields in SLT span gender services (Azul et al. 2022); dementia care (Heuer and Willer 2020); and aphasia (Rogalski and Khayum 2018). Each study showcases a person-centred approach to practice specific to that clinical setting only.

Empirical work considering SLTs' preferences for PCC have generally adopted a quantitative approach e.g. Bellon-Harn et al. (2017) evaluated a quantitative survey used with speech-language pathologists (SLPs) in the USA and found a strong preference for PCC. Similarly, Mahomed-Asmail and colleagues (2023) explored how SLT and audiology students in South Africa understand PCC using an online survey followed by focus groups. In contrast to Bellorn-Harn et al. these authors found that demographics such as age (older individuals were more in favour) and personal attributes influenced the results. Barriers to PCC, such as working in multicultural and multilingual environments, and professional colleagues working in less person-centred ways, were emphasised. Qualitative studies exploring SLTs' conceptualisations and practice of PCC across diverse clinical settings are lacking in the SLT literature. This is where I situate my study.

2.11 PCC and the Covid-19 pandemic

My study took place during the Covid-19 pandemic therefore it is useful to explore the literature on the pandemic's effects on healthcare services and subsequently PCC. Edgar et al. (2020) note how organisational factors such as work stress, staff shortages and multiple changes simultaneously affect the quality of healthcare provision and reduce the person-centredness of the care that patients experience. During the Covid-19 pandemic healthcare organisations and staff had to cope with significant modifications to the workplace and delivery of clinical care.

Dowrick et al. (2021) explore how Covid-19 re-configured care to acute hospital patients through changes in materialities such as space, dictated by infection control procedures. Staff reported difficulties in providing privacy for a 'good death' for patients, while other aspects of infection control such as personal protective equipment (PPE) prevented staff from using touch to increase the humanisation of care. Patients' needs to maintain relationships with family became integrated into healthcare work, with staff facilitating contact via telephone or technology. However, bad news also had to be delivered on the telephone, again reducing the humanisation of care. Staff's own personhood and care for each other's emotional and mental health became more vital during the pandemic, achieved via peer support and informal networks.

Curnow et al.'s (2021) publication explores 97 patients' experiences of healthcare during Covid-19 through a person-centred lens. All individuals except one had contracted Covid-19 and continued to suffer the effects of Long Covid[5]. An initial international online survey was followed by 11 online semi-structured interviews (all participants were UK-based) and the Person-Centred Practice Framework (see section 2.8.1) guided analysis of patient narratives.

Patients reported difficulty in accessing appropriate health services resulted in care that was fragmented and disjointed, based only on physical symptoms. The NHS' focus on treating patients with acute Covid-19 diverted resources away from services previously concerned with long-term conditions, therefore patients with pre-existing conditions in addition to Long Covid failed to access the necessary support. Negative experiences of care occurred at all levels of the Person-Centred Practice Framework. Conversely, a few examples of positive experiences involved HCPs demonstrating person-centredness through active listening, collaboration and acknowledgement of patients' symptoms.

Betancourt et al. (2022) extend the academic focus on healthcare needs during the first year of Covid-19 by including patients' families and healthcare professionals. Their work revealed three main needs associated with HCPs: psycho-socio-emotional, basic and occupational. Basic needs concerned stress associated with wearing PPE for long shifts, high patient numbers and limited opportunities for rest periods. Occupational needs concerned health and safety issues; working conditions; organisational communication regarding the virus; and organisational recognition of staff's key role at this time. Training needs connected to knowledge about treatment, PPE and telehealth. Remaining needs related to improving mental health via formal services,

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[5] National Institute for Health and Care Excellence (NICE): Long Covid is a multi-system condition with a range of debilitating symptoms – signs and symptoms continue or develop after acute Covid-19, continue for more than 4 weeks, and are not explained by an alternative diagnosis. It includes both ongoing symptomatic Covid-19 (from 4-12 weeks) and post-Covid-19 syndrome (12 weeks or more).

resources to aid self-care or alternative means of social support (alternative to staff's usual networks as these were not available during Covid-19).

Patients' needs concerned access to healthcare, support related to mental health and social interaction, and communication with families when hospitalised with Covid-19. Improved communication from healthcare professionals when relatives were in hospital was highlighted by families.

Many of the needs identified have already been highlighted in this chapter as pertaining to person-centred practice e.g. recognising the personhood and wellbeing of both patients and HCPs. Betancourt et al.'s (2022) conclusions are that "COVID-19 amplified the need to provide person and kin-centered care" (p.19), thus personhood and relationality as key elements of person-centredness became more evident.

This chapter now turns to reviewing how multi-level conceptual models have been utilised to think about PCC.

2.12. Progressing a context-bound and dynamic model of PCC in SLT as part of a combined healthcare approach

Conceptualisation of the healthcare system as operating at different levels has already been emphasised in this chapter in Sturgiss et al.'s (2022) review of centredness in section 2.3 and in discussion of the Person-Centred Practice Framework in section 2.8.1. The literature also highlighted the importance of relationality within PCC, and thus a model of healthcare reflecting relational aspects and complexity of healthcare systems is required.

2.12.1 PCC within multi-level models of healthcare

Woolcott et al. (2019) developed a new conceptual model of PCC by combining an ecological systems approach (based on Bronfenbrenner's (1979) model of developmental social ecology) and social network analysis. The authors approached PCC as not only centred on the person but also place-based, i.e. the individual's experiences occur within a specific geographical or community setting.

Bronfenbrenner's model can be understood as a socio-cultural approach where an individual's life is represented as a nested arrangement of five levels of influence, which all interact (Table 2):

Table 2: the 5 levels of Bronfenbrenner's (1979) model, adapted from Woolcott et al. (2019, p.3)

Level	Description
Microsystem	The elements within this system are those closest to the person and interact directly with them. They may be relationships, services or social or cultural factors.
Mesosystem	The microsystem is nested within the mesosystem, which is itself a system of microsystems. The mesosystem consists of the connections between two or more of the elements proximal to the person in their microsystem. Nested within the mesosystem will be different microsystems related to work, family, cultural and social links etc. Within a healthcare context the authors provide the example of a GP collaborating with other HCPs on behalf of the patient.
Exosystem	Elements which indirectly affect the central person, but which have no direct contact with that person. For example, government policy or the media. The mesosystem is also nested within the exosystem.
Macrosystem	Societal beliefs, norms or values which indirectly affect the individual and may have longer-term consequences. All the other levels are contained within this level.
Chronosystem	An examination of how the other four systems interact over time, including a consideration of societal events and history within that individual person's lifetime.

Woolcott et al. (2019) note how Bronfenbrenner's model has been critiqued for its linearity; their use of an additional approach such as social network analysis allows consideration of vertical and horizontal links between networks and systems, creating what they term a 'social ecology network'. This network illustrates factors which influence the person or patient as pathways mapped outwards from the person but shown as pathways across systems rather than within system levels.

Woolcott et al.'s (2019) microsystem consists of factors one step away from the individual. Their conception of a mesosystem comprises factors two steps away, while the exosystem consists of elements three steps away from the central figure. Other connections such as those between proximal factors not directly involving the patient (for example, a HCP interacting with the patient's partner) are considered to be part of the mesosystem as well as the patient's microsystem.

These inter-related factors result in a complex network of systems which influence each other at multiple levels. The authors argue that this model, being place-based, is person-centred as it addresses individual needs and experiences and includes context (place), socio-cultural factors and risk elements. They call for research that "explains emerging patterns of relationships at different levels in social ecology networks and uses them to explain outcomes" (p.7).

The idea that an individual's healthcare needs are context-bound is continued by Rock and Cross (2020) in their publication on PCC within the Australian mental healthcare system. These authors utilise the Institute of Medicine's (2001; 2006) hierarchy of four levels of healthcare systems: 'nano' (individual patient); microsystem (individual HCPs or units of health services); mesosystem (organisational) and macrosystem (policy and regulatory). The authors argue that person-centredness needs to be explicit at each level (although it may be operationalised and look different) while each level needs to inter-connect with each other as well as relate back to the patient. Thus, the idea of healthcare as a complex multi-level system is reinforced, while recognising that to increase person-centredness the values, expertise and experience of patients and staff must be reconciled and integrated with policy and operational plans at the higher levels.

Phelan et al. (2020), in their discussion of how to implement person-centredness, indicate the importance of fostering changes at the level of different systems within healthcare, with an approach such as the socio-ecological model. This model will now be explored in more detail as it shapes the analysis of this thesis.

2.12.2 The Socio-Ecological Model in healthcare research

Throughout this chapter the relationality inherent within person-centredness has come to the fore, and therefore a model of healthcare which emphasises relationships and connections between patients, HCPs, healthcare organisations and wider community, all of which influence and interact, is required. The socio-ecological model (SEM) is one such approach and has developed from ecological models within public health.

Sallis et al. (2008) provide an overview of the historical and conceptual backgrounds of ecological models of health, which focus on “the nature of people’s transactions with their physical and sociocultural surroundings” (p.466). The terms ‘ecological’ and ‘socio-ecological’ are used interchangeably in the literature but more recent publications use the term ‘socio-ecological’. Socio-ecological models used in health behaviour studies contain multiple levels of influence as their core concept and often view these levels as intrapersonal (factors pertaining to the individual); interpersonal (the individual’s relationships with family, social or cultural elements), organisational context and further into policy (Sallis et al. 2008). Golden and Earp (2012) assert “not only that multiple levels of influence exist but also that these levels are interactive and reinforcing” (p.364).

Researchers have utilised the SEM to explore healthcare processes at multiple levels of influence, leading to a variety of scholarly output such as book chapters (Sallis et al. 2008); literature review (Golden and Earp 2012); discussion papers (Hodge and Raymond 2022; Meltzer and Muir 2022); documentary analysis (Phelan and Kirwan 2020); conceptual framework development (Davidson et al. 2018) and empirical research (Shune and Linville 2019; Litchfield et al. 2021; Chen et al. 2023).

The SEM is especially useful in research of clinical practice as it allows exploration and illumination of the many diverse elements which influence and impact on healthcare delivery. These elements range from those pertaining to individual staff, to service and organisational factors and wider into professional and societal standards and norms. For example, Davidson et al.’s (2018) focus is an exploration of ethical issues in nursing and development of a framework to support interventions to encourage ethical practice. The authors adapt and extend Bronfenbrenner’s original model to include eight discrete levels (see Figure 2).

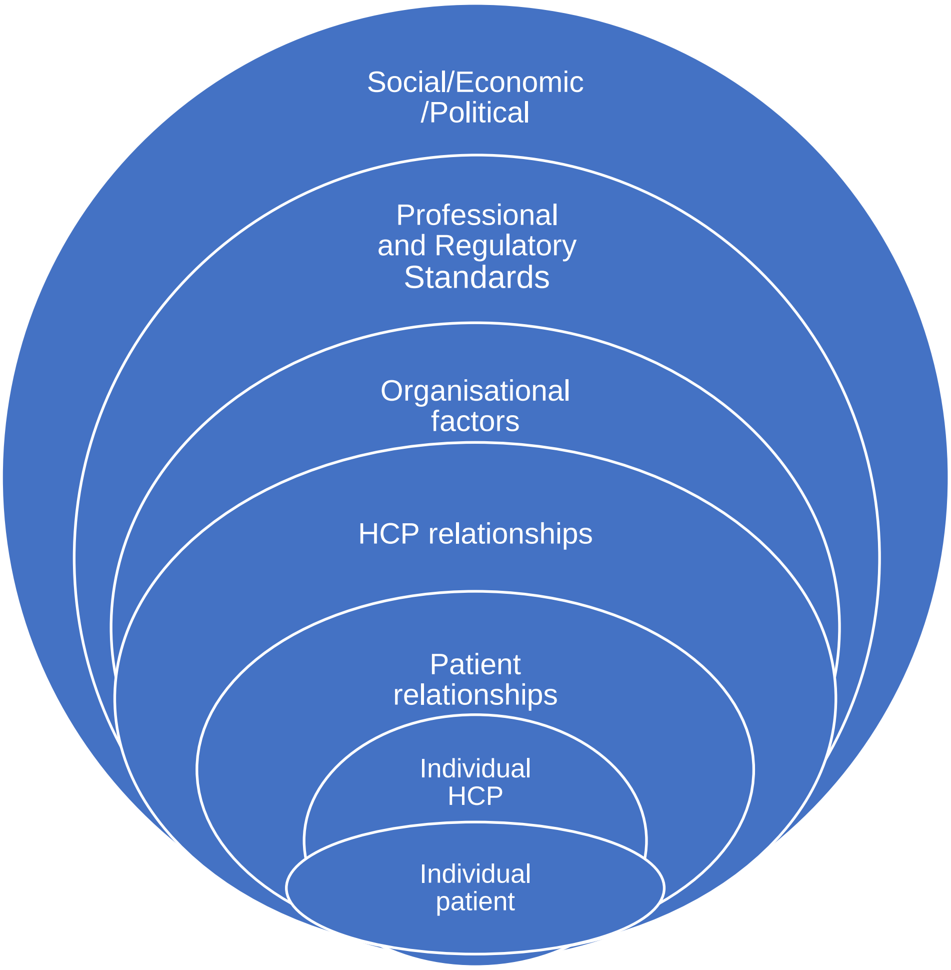

Figure 2 : Davidson et al.'s (2018) adaptation of Bronfenbrenner's (1979) model.

The authors assert that using a socio–ecological framework:

> Can assist in explaining the dynamic interaction between dimensions. Within the context of ethical issues in nursing, this can also help illuminate the factors that both help and hinder ethical practice and environments that not only promote the quality and safety of patient care but also enable positive practice environments within which nurses can practice ethically. Similarly, they can help to identify the inter-relationships among the elements that impact individual and collective practice of nursing and the outcomes for the people they serve.
>
> (Davidson et al. 2018, e1235).

The model can be used to explore different aspects of practice at individual, interpersonal and organisational levels (and beyond). Shune and Linville (2019) utilise the model to investigate barriers and facilitators to improving the dining experiences of residents in care homes, including those with swallowing difficulties (dysphagia). As the authors note, eating and drinking is a social activity, performed within social contexts and empirical exploration needs to consider the myriad elements which can impact on this experience:

> Dysphagia also encompasses the context within which swallowing occurs. From eating and nutrition to social interaction and community building, mealtimes are crucial for human functioning. Dysphagia's impact on the individual thus extends well beyond the impairment itself and interventions need to be comprehensive.
>
> (Shune and Linville 2019, p.152)

The SEM allows elucidation of personal and environmental influences and thus clarifies where intervention needs to be targeted for sustainable improvement. In a similar process, Chen et al. (2023) employ a socio-ecological model to analyse themed interview data, resulting from inquiry into palliative care services for patients with Parkinson's Disease. They also utilise the model to look at barriers and facilitators at each level.

This section has reviewed how multi-level models of healthcare such as the SEM allow illumination of factors at different levels which influence healthcare delivery. The model emphasises relationships and connections between people, organisations, community and beyond, which aligns with a socio-cultural approach with relationality as a key element.

2.13 Relationality in this thesis

The concept of relationality applied in this thesis is a pragmatic application, recognising the patient in relation to family, friends, socio-cultural context, place and healthcare systems, or in practical terms, where each level of the SEM represents a relation that should be included in the study of PCC. The SLT also sits in a network or relations with patients, colleagues, and embedded within institutional systems and policies, that cut horizontally as well as vertically across the levels typically depicted in the SEM. Despite the plurality of the concept of relationality in the sociology literature (for example Mead (1934); Elias (1978); Emirbayer (1997)) I am using the idea of relationality as the connections and relationships between people, their contexts, and socio-cultural networks; my interpretation is a practical application of different models, where interaction between social beings is key (for example Crossley (2011; 2015)).

2.14 Chapter summary

This chapter has explored the development of the concept of person-centredness within healthcare, noting its relational construction and the importance of including the personhood of all those involved in the care process- stakeholders comprising patients, families and HCPs. The literature argues that person-centredness is predicated on underlying culture and shared language within the workplace.

Feldthusen et al. (2022) consider that “centred care is an act based on relationships and communication” (p.897). The idea of relationality as a key element of person-centredness is often mentioned in the literature and refers to the person as integrated within networks and webs of relationships, extending out from the person into family, friends, community and other contexts, including healthcare systems. According to the literature, the view of placing the person within their social and cultural communities reflects a non-Western perspective of PCC, although most of the empirical research within the field of PCC is still situated within a Western approach to practice.

Within this chapter I have also considered the literature regarding PCC during Covid-19, and how materialities of care and person-centredness were impacted at this time. The study of person-centredness through the lens of Covid-19 has shown how attainment of good pandemic control through such measures as infection control procedures, social distancing and limited social connectedness does not necessarily correlate with practising person-centredness in a healthcare context.

This chapter considered that a socio-ecological model of health offers a means of integrating all the myriad elements within healthcare which interconnect and influence clinical practice. It is argued that it can help to illuminate the different levels of healthcare and the relationships which are important between and across those levels, with the patient/person at the core. I am interested in exploring what this looks like for SLT as a health profession with communication and facilitating relationships at its core.

Finally, consideration of the literature on PCC within SLT revealed the limited number of qualitative studies. More research is needed not only on how SLTs conceptualise

PCC but on what they actually do, and how this compares to the person-centred practice of other HCPs. Ultimately this has implications for policy, practice and education of SLTs.

This literature review has revealed a gap in the SLT professional and wider healthcare literature regarding qualitative research on PCC, in particular SLTs' conceptualisations of PCC across broad clinical contexts. There is limited exploration of the values underlying SLTs' person-centred practice and research on this might ensure appropriate focus on the importance of values in PCC. Additionally, investigation of SLTs' role within PCC and within the socio-ecological model of healthcare is lacking, particularly during a time of crisis such as Covid-19, when healthcare staff and services experienced severe pressures. As I explain, I did not initially intend to study this crisis, yet the idea of health services being in crisis and not delivering, is significant for PCC.

The research questions emerging from this literature review are therefore:

RQ1: What is SLTs' role within person-centred care and how do their values shape their practice and professional identity?

RQ2: What are the processes and relationships that facilitate or hinder PCC within SLT clinical practice?

RQ3: How can a socio-ecological framework, in combination with elements of systems thinking, contribute to our thinking on person-centredness within SLT clinical practice?

Chapter 3 - Methodology

Overview

This chapter clarifies the methodology and accomplishment of this mixed-methods study. I situate the study methodologically within the professional SLT and wider healthcare literature and identify the gaps that this study aims to address. I review not only the study design but the challenges inherent in my position as an 'insider' researcher, with its related ethical considerations (Floyd and Arthur 2012; Hayfield and Huxley 2015).

3.1 Aims and Research Questions

This study aims to explore SLTs' conceptual understanding of person-centredness and how they enact this in clinical practice. It focuses on critically understanding SLTs' role in person-centred practice and how personal and professional values shape practices and professional identities. It considers how Appreciative Inquiry (AI) can be used as a tool to explore SLTs' conceptualisations and practice of PCC, especially in the context of the Covid-19 pandemic in the UK National Health Service (see Armstrong et al. 2020; Cooperrider and Fry 2020).

The key research questions are therefore:

RQ1: What is SLTs' role within person-centred practice and how do their values shape their practice and professional identity?

RQ2: What are the processes and relationships that facilitate or hinder person-centredness within SLT clinical practice?

RQ3: How can a social-ecological framework, in combination with elements of systems thinking, contribute to our thinking on person-centredness within SLT clinical practice?

RQ4: How can the methodological approach of Appreciative Inquiry (AI) be used to explore SLTs' conceptualisations and practice of person-centredness?

These research questions are underpinned by 2 aims:

- How do SLTs understand the concept of person-centredness?

- What are the values and practices that underpin their understanding of person-centred practice, including potential future developments in practice?

3.2 Ontology and Epistemology

The ontological and epistemological positions underpinning this project is that of social constructionism (Gergen and Gergen 2015) and interpretivism (Black 2006). In a constructionist framework, knowledge is co-created through social interaction and practices (Gergen 2009). Hosking (2011), McNamee and Hosking (2012) and McNamee (2020a) refine this further to reflect the relational processes which they consider to be key in the construction of our world: they term this relational constructionism.

A relational constructionist world view takes the stance that there are multiple realities, all constructed "as a process of inter-action" (McNamee and Hosking 2012, p.38) between different social actants, which can be both human and non-human. These are 'realities' created within social interactions and processes and thus can be otherwise described as socially and relationally situated.

The idea that data generated in a research project is constructed through making sense of meaningful relationships between the individual and the world in which their experiences are situated resonates well with a project located in a healthcare setting where clinical practice is reliant on the relationship between clinician and patient, as well as between medical institutions and everyday experience. The relational nature of clinical practice cannot be over-emphasised, with practitioners and patients both vital social beings in the processes of producing medical knowledge (Terry and Kayes 2020). A methodological approach that reflects this interpersonal relationality was therefore required. The methodology employed for this study, as I will explain, aims to support the generation of data too, for other forms of relational construction that will emerge, both in the clinical practice explored, and those aligned with the relational elements of the research process, such as collaboration and co-construction of situated knowledge. As Hersted et al. (2020) assert:

> Social constructionist theory lends itself to an ontology in which relationships precede the individual.
>
> (Hersted et al. 2020, p. 11).

Another key element of the relational constructionist paradigm is that it provides a means for exploring local knowledge, which is itself based on cultural assumptions, and shaped by personal and organisational values and beliefs. AI is a methodological approach underpinned by social constructionism (Cooperrider et al. 2008) and was chosen as the form of inquiry for this study. The next section clarifies this approach further.

3.3 Methodological approach

The choice of AI reflects the opportunity of a methodology that allowed exploration of the concept of person-centredness in practitioners' day-to-day work, revealing elements that work well while providing opportunity for change, but basing this in the constructionist ontology previously described. AI is a form of Action Research (AR) and therefore an overview of AR's approach to social research is relevant.

3.3.1 Situating Appreciative Inquiry within Action Research methodologies

Hersted et al. (2020) provide a synopsis of the history and origins of AR, noting how AR combines the three elements of action, research and participation, in addition to collaboration and reflexivity, where dialogue between researcher and participants is key. The knowledge gained from an AR process is knowledge that is useful for participants' everyday lives. Hersted et al. (2020) also comment on the myriad epistemological positioning underpinning the different approaches to AR.

Critiques of AR usually result from a positivist worldview where a single reality is favoured. Researchers with a positivist background may dispute research where the researcher plays an active role in the co-creation of local, tacit knowledge privileging multiple voices and understandings (Gordon 2020, drawing on Kemmis 2008). In the AR process, novel ways of knowing then disrupt traditional ways of thinking leading to transformational change secondary to learning through partnership.

3.3.2 Overview of Appreciative Inquiry

Clouder and King (2015) present a complete history of AI. Whilst the concept of AI is attributed to Lewin (1946), the term 'Appreciative Inquiry' was created by Cooperrider and Srivastva (1987) within the context of organisational change. This was in response to dissatisfaction with problem-based models of action research (AR), which were felt to be ineffective in instigating sustainable change at organisational levels and to stifle feelings of growth and energy in participants:

> [Action research's] steadfast commitment to a problem-solving view of the world is a primary restraint on its imagination, passion, and positive contribution; that appreciative inquiry represents a viable complement to conventional forms of action research, one uniquely suited for social innovation instead of problem solving; and that through our assumptions and choice of methods we largely create the world we later discover.
>
> (Cooperrider and Srivastva 1987, p. 169)

AI is a framework that encourages participation at all levels of an organisation and has been defined by Watkins and Mohr (2001) as:

> A theory and practice for approaching change from a holistic framework. Based on the belief that human systems are made and imagined by those who live and work within them, AI leads systems to move toward the generative and creative images that reside in their most positive core – their values, visions, achievements and best practices.
>
> (Watkins and Mohr, 2001, p.262)

AI explores what works well in organisations or teams using affirmation and positive dialogue, using the rhetorical device of 'changing the narrative' as a starting point for transformational change. The concept of 'generative thinking'[6] (Bushe 2013), for example the use of metaphor, has been identified as a key lever of change in AI, allowing illumination of the participants' underlying values.

3.3.3 AI and social constructionism

AI is based on a social constructionist viewpoint, and as Cooperrider et al. (2008) assert:

> AI takes this theoretical framework [social constructionism] and places it in a positive context. This positive spin on social constructionism is central to AI.
>
> (Cooperrider et al. 2008, p.14).

As I have already noted in section 3.2, social constructionism highlights social interaction and practices, with human relationships at its core (Gergen and Gergen

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[6] Bushe (2013, pp.91-92): generativity occurs when a group of people discover, create, and/or are presented with an image that allows them to experience their work and organization differently…A generative image allows people to see the world anew, identify new options, formulate new strategies, even reform their identity.

2015). Within a relational AI approach, the focus is on relational processes, with the aim of appreciating how people understand and construct their value in their everyday world. The multiple realities inherent in social constructionism is brought forth via dialogue, where language and discourse are the means whereby the particular social world of the research participants is co-created and understood (Hersted et al. 2020).

McNamee (2020b) notes that from a relational constructionist perspective, “language constructs the world” (p.18) and that distinct communities, for example specific teams within an organisation, create their own language community through which they understand their professional world, practice or organisation. A researcher who approaches their research from a relational constructionist viewpoint therefore attempts “to create a new understanding of the world” (McNamee 2020b, p.19) through participants’ narratives, elicited through the relational process of dialogue.

Both AR and AI aim to give rise to a transformation within the system being researched, co-created by researcher and participants. McNamee (2020b) emphasises how the relational processes of AR (also applicable to AI) provide space for multiple voices to be heard, leading to multiple ways of understanding their social world, which she terms “discursive potential”. McNamee considers that facilitation of these multiple voices and discourses through collaboration between researcher and participants is relationally ethical:

> The ethic of discursive potential underscores the humanizing aspect of action research. In giving voice to multiple understandings, action research unites participants in negotiating their futures together. It acknowledges the ways in which all social action rests within a matrix of relationships with multiple actors, multiple contexts and multiple social discourses.
>
> (McNamee, 2020b, p.31)

The above quotation not only highlights collaboration and co-construction of futures, but also emphasises the numerous relationships, multiple actors, and countless social contexts where social relationships take place. The complexity of social worlds is illuminated and use of the socio-ecological model of healthcare to guide data analysis (see section 3.8) aligns well with a data collection method which emphasises webs of connection, interaction and relationships.

The social constructionist stance of AI forms one of the five key principles of the AI process (Cooperrider et al. 2008). These principles are discussed in depth later in this chapter. The AI process consists of a ‘4D cycle’ - Discovery, Dream, Design and Destiny (or Appreciating/Envisioning/Co-Creating and Embedding – Watkins et al. 2016). Participants are asked to explore the ‘affirmative topic choice’ at the core of the cycle focusing on current and future practice. Methods used in AI can span a wide range but usually emphasise narrative methods where positive stories are shared.

Each phase of the cycle explores the topic from different aspects (see Figure 3). The Discovery phase explores how the topic is done well currently, that is, what is working well, while the next ‘Dream’ phase imagines what ‘might be’ i.e., the ideal way of working. Bushe (2013) notes that “the purpose of the dream phase is to surface the values and aspirations that enliven the system” (p.11). The Design phase focuses on ‘what could be’ while Destiny, the final phase, is concerned with generating actions to enable and sustain the ideal.

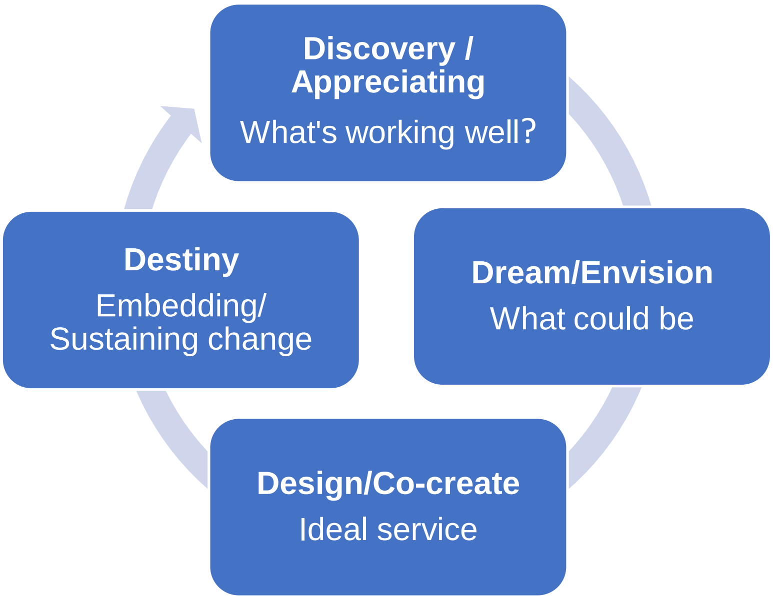


Figure 3: phases of the AI process, adapted from Cooperrider & Whitney (2005 p.16)

Gordon (2020, drawing on Bushe (2011) and Cooperrider et al. (2005)) notes that each phase is underpinned by a different theoretical aim (Table 3):

Table 3: the different theoretical aims of each phase of the AI cycle Gordon (2020, p.95)

Phase	Theoretical foundation	Application
Discovery	Interpretive	Observing and describing the best of what is. Often through storytelling.
Dream	Experiential	Through a reflexive and questioning approach, explore ideals of what might be. Seeks appreciation of the organisation.
Design	Normative and constructivist	Seeks practical knowledge through collaborative dialogue. Collective agreement on the desired future.
Destiny	Pragmatic	Seeks knowledgeable action, collective innovation and improvisation

Underpinning the practical and conceptual aim of each phase are five key principles (Cooperrider et al. 2008):

- **The (narrative) constructionist principle:** – reality is co-constructed through interactions and relationships, which are themselves based on language and dialogue i.e., “words create worlds” (Bushe 2011, p.91). Reality therefore is discursive, dialogic and socially situated; as Arnold et al. (2022) note “The stories that are told in teams, the images and language that are used, mould them. Therefore, the stories that are told during AI are key, because they become part of the narrative, identity, and culture” (p.3).
- **The principle of simultaneity:** – inquiry generates change from the outset through asking questions which make participants look at the topic in a new way. This results in staff recalling positive experiences at work and uncovering

their professional or personal values, all of which aim to generate a change in mindset. Further questions and dialogue maintain this momentum.

- **The poetic principle:** – the topic of inquiry shapes what we then discover. The stories that are recounted about the things we regard highly or appreciate the most “constantly recreate the story of [the] organisation like a poem” (Clouder and King 2015, p.4). These stories then act as a stimulus for change.
- **The anticipatory principle:** – the vision for the future that is created collaboratively then influences current behaviour.
- **The positive principle:** – positive thinking maintains the impetus for change. Positivity helps redirect people’s attention away from a problem-based discourse towards what excites them in work.

Positivity is considered to be a key principle in AI, where positive images and emotions generated create an energy within the participants, leading to positive actions (Cooperrider et al. 2008). Positivity alone, however, is considered by Bushe (2013) to be insufficient to enable transformational change, and the addition of generativity is vital as it then acts as a key change lever. Bushe (2013) defines generativity as “the creation of new images, metaphors, physical representations” (p.89) and deems it “the process and capacities that help people to see old things in new ways” (p.89). This is represented by Bushe (2013) as a change in narrative that shapes new thinking, ultimately affecting actions and behaviours, which over time lead to changes in culture due to the creation of a new normative order. As Bushe (2013) notes, the culture change which arises secondary to an AI process occurs not so much from action plans but from changes in how people think and act in their work every day (p.92).

AI aims to achieve change by viewing existing praxis in a different way and by using dialogue as a generative device during the ‘poetic’ stage (Bushe and Kassam 2005). Further generativity is achieved by use of imagery and the telling of stories:

> The use of imagery, metaphor and stories help to deepen inquiry and enables people to articulate tacit, intuitive and unconscious knowledge. These are all important ways to voice and share the personal and tacit knowledge that is embodied in practice, so enabling a different quality of response and encouraging a range of different voices to be heard (Reed, 2007).
>
> (Sharp et al 2018, p. 234)

The role of language and dialogue as a generative process within research conversations is discussed by Larsen and Madsen (2020) in the context of AR. They introduce the term 'social poetics' (p.56) which considers how the language used in everyday interactions shapes people's life. Within AR, social poetics as a research practice (using such tools as metaphor) invites generativity as it allows participants to see new connections and is future-forming (Larsen and Madsen 2020).

It is therefore the process of inquiry itself, via appreciative and generative dialogue, that is the core of AI, as potential transformation is based on changing the mindset of practitioners and therein the local culture. This is achieved through changing the stories of the participating group(s) or "changing patterns of narration" (Cooperrider et al. 2008, p.15), leading to behaviour change, with the recognition that behaviour and actions are predicated on people's beliefs, values and sense-making, all embedded in language.

Having explored the conceptual underpinning and key elements of its methodology, I now move on to the use of AI and what it can offer at times of crisis such as the Covid-19 pandemic.

3.3.4 Appreciative Inquiry and Covid-19

At first glance, utilising a method that searches for what works well or gives life to a healthcare service during a pandemic may seem paradoxical or irrelevant. However, Cooperrider and Fry (2020) consider that AI can assist workforce resilience and identify developmental change opportunities even at times of crises such as the Covid-19 pandemic. To illustrate their argument, the authors draw on Cooperrider's (2018) work on the three levels of AI, with AI into the *extraordinary* (examples of 'positive deviance') as the easiest level to appreciate. The next level concerns AI during *ordinary* times, when noticing what gives life during mundane events or activities requires more effort. At the top of the pyramid-model lies AI in times of *tragedy* which is the most challenging and complex, but even at these times the best of the system under scrutiny can appear and grow.

In their view, appreciative practices can help to reframe challenges and reveal opportunities for change and "AI holds myriad potential benefits for individuals, communities, and macro systems to build resilience and promote growth during and after COVID-19" (Armstrong et al. 2020, p.1). These authors consider that AI achieves this through its focus on strengths as it "increases quality of life, productivity, work engagement and retention" (p.3) thus benefitting both individuals and organisations. In their study on midwives' wellbeing during Covid-19, Arnold et al. (2024) assert that use of AI:

> Gave participants a rare opportunity to reflect on their work and values. This became a therapeutic wellbeing intervention for some staff under stress.
>
> (Arnold et al. 2024, p. 8).

In their study, staff's reflections on their achievements during an extremely challenging period, both professional and personal, increased their wellbeing and this then fostered resilience. Cooperrider and Fry (2020) note that it is at these times of tragedy that "values can come alive and be intensely lived" (p.266), therefore the use of AI to explore a practice such as person-centredness, which is underpinned by professional and personal values, during the period of Covid-19 appears very relevant.

3.3.5 Critiques of Appreciative Inquiry

Critiques of AI are evident in the action research literature and are based on three main areas: a) its focus on positivity; b) its potential to achieve true transformational change and c) the rigour of its methodology.

a) Positivity

Critics regard the focus on positivity as an exclusion of other perspectives (Duncan and Ridley-Duff 2014). Arguments against AI assert that lived experience includes both negative and positive elements, and the process of AI should not supersede the human experience (Fitzgerald et al. 2010, drawing on Pratt 2002).

Fitzgerald et al. (2010) also note that the AI process can generate what they term 'the shadow', by which they mean raising awareness of negative or underdeveloped aspects, which are just as valuable as the positive elements. Bushe (2010) welcomes this review by Fitzgerald et al. and reminds us that Cooperrider's main intention was for AI to be a more rounded means of inquiry into what gives life to an organisation and not to focus purely on the positive. During the AI process space needs to be available for negative feelings, emotions and issues so that they are acknowledged but in a way that is more appreciative and productive (Bushe 2013).

Within healthcare, Arnold et al.'s (2022) AI study into nursing staff's wellbeing during Covid-19 also acknowledges the 'shadow' (namely Covid-19) in an appreciative way during staff focus groups. The authors note recognition and acknowledgement of the pressures and impact of Covid-19 on staff's professional and personal lives created space for staff to share anxieties and worries, which staff valued:

> It was clear that the 'COVID question' was important, not only because it acknowledged the tumultuous events but also because it gave space for staff to bring their whole self to the interview – not simply their professional persona. This helped to create authenticity and an open communicative space.
>
> (Arnold et al. 2022, p.4)

Jones and Masika's (2021) study into pedagogical development in higher education adopts an AI approach - the authors also argue that incorporation of the shadow provides a more holistic understanding of the processes necessary for transformational change. Acknowledgment of the shadow or negative stories also prevents polarised discourses or a simplified positive focus (Bushe 2011; Sharp et al. 2018). Bushe (2011) also advises that unless AI attends to issues that really matter to participants then transformational change will not occur, therefore attention to both positive and negative aspects are important.

b) Potential for transformational change

Bushe (2011) asserts AI is a powerful and effective change process when performed by a proficient facilitator, however many publications claiming to be AI do not include detailed accounts of the processes followed in the research, affecting the ability to compare studies. Bushe and Kassam (2005) define transformational change as "changes in the identity of a system and qualitative changes in the state of being of that system" (p.162). In their review of transformational change instigated by an AI process, Bushe and Kassam (2005) considered that only 35 percent of the publications reviewed had achieved such change. Criteria for transformational change included generation of new knowledge, a generative metaphor and an improvisational approach in the Destiny phase. Although all papers reviewed claimed to be successful AI interventions, Bushe and Kassam (2005) considered the variables in process and outcomes reported affected the potential for transformation.

Within *healthcare,* reviews of AI's effectiveness in transformational change have been mixed. The utilisation of AI as a means of practice development within nursing is considered by Watkins et al. (2016) in their integrative review and narrative synthesis of the literature. Only one project out of the eight papers reviewed achieved what the authors considered to be transformational change, due to inconsistent application and operationalisation of AI principles. In their view, critical evaluation of the impact of AI within nursing is therefore difficult to achieve.

Merriell et al.'s (2022) systematic review of the impact of AI within healthcare generally concluded that while there is some evidence of change in participant reactions, attitudes, knowledge, skills and behaviour, there is insufficient high quality empirical evidence to demonstrate effectiveness of AI. However, other evidence such as qualitative and observational evidence did suggest a potential for improved outcomes in clinical care leading the authors to call for further high-quality research.

Sharp et al.'s (2018) publication concerns a change programme in Scotland where an appreciative AR design engaged care home staff and enabled sustainable transformational change. The authors argue that a relational focus to change was essential as "relational dynamics are rooted in the daily dilemmas and tensions of everyday practice" (p.227). The authors considered that highlighting relational practice required professionals to review their own personal and professional values and conduct. It also necessitated a shift in mind-set regarding traditional ways of working and this new way of thinking underpinned the transformative and generative potential of AI.

AI has also been applied specifically to implement improvements in PCC. Hung et al. (2018) report how an AI approach, through knowledge translation, supported interdisciplinary practice development to enact person-centred dementia care on a medical unit in a large Canadian hospital. This study demonstrated this approach had potential to motivate staff to change practice, particularly through the empowerment of staff as change agents. The authors also considered an important element of the study design to be attention to the relational aspects of care. Scerri et al. (2019) utilised an AI approach to facilitate and evaluate workshops into person-centred care in dementia, after which positive and noticeable changes were noted in staff attitudes, practices and inter-disciplinary working.

An Australian study by Drayton et al. (2021) explored a new model for person-centred goal setting in a rehabilitation unit for adults through an AI approach, including both rehabilitation staff and clients. Relational elements are again highlighted as AI, in conjunction with practice development methods, provided a safe space for the team to build effective relationships which enabled person-centred goal setting with clients.

c) Methodological rigour

The wide range of conclusions about the effectiveness of AI as a methodological tool could be attributed to the lack of methodological consistency when undertaking and reporting AI, as found in a review of AI studies in healthcare (Trajkovski et al. 2013). Clouder and King (2015) also note how lack of detail and transparency concerning process in the AI literature results in difficulty in evaluating it as a research method, particularly “assurance of rigour, trustworthiness and authenticity of findings” (p.11). Gordon (2020) however draws on van der Haar and Hosking (2004) and Grant and Humphries (2006) when noting that evaluation of AI needs to occur from a relational constructionist perspective and particularly the adoption of a critical reflexive stance throughout the AI process. With the literature on relational constructionism providing an encouraging picture for the future of AI research, this is where I situate my current study.

3.3.6 Summary

Person-centredness as explained through socio-ecological and conceptual thinking is a relational concept. Generation of data about PCC in SLT required a methodology that was relational and reflexive. Indeed, Dewar et al. (2016) note:

> What is important for person-centred practice or relational practice is that the philosophical values of exploring the uniqueness, wholeness and essence of human life in the context of one another are central to the research design.
>
> (Dewar et al. 2016, p.121)

This section has shown that AI is underpinned by social constructionism, recognising multiple voices and realities. AI adopts an approach which is collaborative, participatory, privileges relationships and is a research approach which “create[s] a positive relational language of inquiry and dialogue” (Dewar et al. 2016, p.121).

In addition, as discussed in Chapter 2 (section 2.7) development of person-centred practice is linked to an underlying change in culture within teams and organisations. A methodology such as AI that is not only relational but ultimately claims to shape a new mindset and culture is a ‘good fit’ for my study. The next section describes how AI was used as a specific methodology.

3.4 Study Design

This study sought to unpack the reality of daily practice within a specific clinical service (see section 3.6.2 for a description of the setting) at a particular period in time using AI, and to compare this local dimension with knowledge generated nationally across the UK through a national survey. The aim was to generate in-depth qualitative data to explore SLTs’ conceptual understanding of PCC and its application in clinical practice across the profession in the UK.

Engaging with the staff delivering in a local service using the AI process approach described earlier was therefore vital. Here the participatory and collaborative approach of AI was also important because its sensitivity to organisational context means that the method was attuned to ensuring that all voices were heard within a non-hierarchical framework. The focus of the data generation process was the development of local knowledge about PCC, co-created by researcher and participants.

The study was planned in a series of phases, each phase addressing one or more Research Questions (see Table 4).

Table 4: Research questions, methods and sources.

Research Question	**Research method & source**	**Participants**
RQ1: What is SLTs' role within person-centred practice and how do their values shape their practice and professional identity?	Workshop: 1.Visual Inquiry (Roddy et al. 2019; Bessette and Paris 2020) 2.Cake Metaphor Activity (Nind and Vinha 2016).	SLT staff within five different clinical settings within a particular adult service (see Table 5).
	Digital Diaries (Jarrahi et al. 2021)	As above
	Online Survey (Braun et al. 2021).	Practising SLTs across the UK (see section 3.4.1).
RQ2: What are the processes and relationships that facilitate or hinder person-centredness within SLT clinical practice?	Workshop: AI Process (Cooperrider and Whitney 2005; Cooperrider et al. 2008; Cooperrider and Fry 2020).	SLT staff within five different clinical settings within a particular adult service (see Table 5).
	Online survey (Braun et al. 2021).	Practising SLTs across the UK (see section 3.4.1).
RQ3: How can a socio-ecological model (SEM) contribute to our thinking on person-centredness within SLT clinical practice?	Use of the SEM to evaluate qualitative data generated via the methods detailed above (Davidson et al. 2018)	All data generated through the mixed-methods.
RQ4: How can Appreciative Inquiry be used to explore SLTs' conceptualisation and practice of	Workshop: AI Process (Cooperrider and Whitney 2005; Cooperrider et al. 2008; Cooperrider and Fry 2020).	SLT staff within five different clinical settings within a particular adult service (see Table 5).

person-centredness?	Online Survey questions informed by the AI literature (Cooperrider and Whitney 2005; Cooperrider et al. 2008; Braun et al. 2021)	Practising SLTs across the UK (see section 3.4.1).

Workshops: The first phase was a workshop with SLT staff within five different clinical settings within a particular adult service (see Table 5). The researcher acted as an appreciative inquirer in these workshops, using positive questions and other methods such as patient stories, with exploration of values and beliefs through use of metaphor and visual methods (see section 3.5.3).

Five separate clinical teams were identified across a Health Board, representing different types of adult SLT practice. Each clinical team acted as a separate 'stakeholder' group and had its own AI workshop to tease out any differences between clinical sites. Clinical settings (5 in total) are reflected in the number of workshops, for example acute hospital wards (1 team), rehabilitation wards (2 teams – brain injury and stroke), out-patients (1 team) and community (1 team). Secondary care therefore accounted for 60% of the teams while 40% worked in primary care or community settings (see Table 5).

Table 5. Key to data sources and participants (online survey participants are prefixed with P-, while staff participants are anonymised by use of pseudonyms).

Data generation method and setting	**Date and Context**	**Participants (pseudonyms)**
Online survey	**March – June 2021**. During the tail end of the second wave of Covid.	P1-80
Staff electronic diaries /reflections	4 weeks prior to and 4 weeks after each staff workshop, completed either individually or in clinical teams. Only one team completed diaries pre and post workshop.	Pre- workshop = 42 entries. Post workshop = 17 entries.
Brain Injury Rehabilitation staff workshop	**June 2021**- between 2nd and 3rd waves of Covid. Services which had been closed or disrupted during the first two waves now resumed. Significant backlog of patients identified.	Katrina Sadie Sharon Sabrina Rachel Anne (total = 6)
Out-Patients staff workshop	**August 2021** – between 2nd and 3rd waves of Covid. Services which had been closed or disrupted during the first two waves now resumed. Significant backlog of patients identified.	Joyce Stella Charlotte Ava (total =4)
Stroke Rehabilitation staff workshop	**November 2021** – 3rd wave of Covid. Continuation of services resumed after previous closure in addition to severe operational pressures due to: numbers of people hospitalised with Covid; reduction in beds available for admissions due to inability to discharge patients secondary to the workforce crisis in health and social care in the community; significant backlog of patients waiting for treatment; exhausted healthcare workforce.	Nadia Tara Lily Enya Laura Fran (total =6)
Acute wards staff workshop	**December 2021** – 3rd wave of Covid. Continuation of services resumed after previous closure in addition to severe operational pressures due to: numbers of people hospitalised with Covid; reduction in beds available for admissions due to inability to discharge patients secondary to the workforce crisis in health and social care in the community; significant backlog of patients waiting for treatment; exhausted healthcare workforce.	Carol Nancy Siobhan Helen Elaine (total =5)

Data generation method and setting	**Date and context**	**Participants (pseudonyms)**
Community staff workshop	**February 2022** – 3rd wave of Covid. Continuation of services resumed after previous closure in addition to severe operational pressures due to: numbers of people hospitalised with Covid; reduction in beds available for admissions due to inability to discharge patients secondary to the workforce crisis in health and social care in the community; significant backlog of patients waiting for treatment; exhausted healthcare workforce.	Eva Mark Katy Odette (total =4)

Inviting existing SLT teams across a variety of settings to participate in the study was due to consideration of research literature findings that clinical setting may dictate the kind of centredness that is 'done' in practice (El Alti et al. 2019; Waters and Buchanan 2017). Socio-cultural context and team issues are also contributory factors and may vary across settings. Organisational elements may be common across all settings, reflecting values and aims driven by the organisation. Each member of the five clinical teams was also asked to keep an electronic weekly diary to reflect on therapy interventions during the week. This is detailed further in this chapter in the section on data collection procedures.

Survey: The final phase of the project, running simultaneously with the workshops, was an online survey of practising SLTs across the UK. This survey also adopted an AI approach in the qualitative questions asked. The data generated by the survey was both qualitative and quantitative (see Appendix 5). The qualitative sections explored the same themes as the workshops, using positive questions about practice, exploring values and beliefs and asking for patient stories. The aim was to integrate both sets of narrative data with the intention of achieving conceptual clarity regarding understanding of person-centredness across the profession. The quantitative data was mainly demographic in nature (see section 3.5.1).

Qualitative data collection via an online survey is a useful research tool, allowing a "wide-angle lens" on the study topic through its ability to access and capture a large number of responses (Braun et al. 2021, p.643). The online survey in my study was distributed via professional clinical networks (via RCSLT) across a variety of SLT clinical settings and specialisms, thus capturing SLT participants possessing a wide range of experience and training. In this way sense-making across the profession (or at least SLTs working with adult patients in the UK) was feasible.

3.4.1 Participants and recruitment

The SLT staff for the participatory workshops were those working within the researcher's own service. The ethical implications of this are discussed later in the chapter. Recruitment was purposeful and staff were invited to engage in a service-wide evaluation of current practice via a gatekeeper within the health board. Study information was provided both verbally and in written form (see Appendix 3). A total of 25 staff, out of a possible 50, participated in the workshops, due to unavailability of staff secondary to clinical pressures during Covid-19. Workshops were organised according to the different clinical settings as already shown in Table 4.

SLTs for the online survey were recruited across the UK via professional clinical networks. A total of 80 responses were received representing SLTs working across acute wards, in-patient rehabilitation wards, community settings, mental health and hospice backgrounds.

3.4.2 Consent

Staff workshops and electronic diaries – the researcher held a service-wide project briefing meeting to present the project to staff prior to any consent being sought. The researcher discussed the project with each staff clinical team and provided them with written information outlining the project, what participation involved, consent, data management and reporting. Each participant was given a week to reflect on the project aims before being asked to complete consent forms. However, staff had the opportunity to discuss questions or queries with an independent person within the health board before consenting to participate.

Only consenting participants were able to take part in the study. As the participatory and collaborative nature of the data generation and analysis was about generating a shared approach to service evaluation and provided an opportunity for service transformation, it was anticipated that local staff would be fully engaged in the AI workshops and would attend each session. Consent was however re-visited on an ongoing basis after each workshop and staff were able to opt-in or out of the project at any time (in writing or in person to the PI). The participant information sheet form also explicitly stated the right of each participant to withdraw at any time. Any data up to the point of anonymisation already collected from that individual would be destroyed. During the workshops the researcher was guided by HCPC and RCSLT standards, and this was stated clearly in the participant information sheet.

Online survey: – Interested participants who clicked the link to the survey were presented with information on the entry page outlining the project, what participation involved, the survey, data management and reporting. Participants were asked to confirm their consent to progress. Participants were unable to progress to the survey without indicating their understanding of the participant information and consent to participate. Their right to withdraw was also highlighted although point of withdrawal was to be up to final electronic submission of the survey.

3.4.2.1 Data Management

Data management is shown in Table 6:

Table 6: data management.

Digital Diaries	These were deleted from the general SLT shared drive and stored electronically in a secure, password–protected separate folder. As the researcher was a NHS employee, storage was via both Health Board and Cardiff University IT systems due to long-term accessibility to the data.
Patient stories	These were scanned and stored electronically in the same folder as above. The original written sheets were kept in a locked filing cabinet within the SLT department
Flip chart notes	The themes were photographed and scanned into the same folder as the diaries and worksheets. Themes were summarised in a separate document by the researcher, scanned and stored in the same folder. The original flip charts were kept in a locked filing cabinet within the SLT department
Audio-recordings	Data collected via audio-recording were transcribed as soon as possible by a Cardiff University approved transcription service. Due to work pressures secondary to Covid, the researcher did not have time to transcribe these personally. When transcripts were received by the researcher, they were anonymised and then deleted from the recorder. Transcriptions were stored electronically in the same folder as the remainder of the data.

All data management adhered to GDPR regulations. Data will be retained in line with GDPR guidance for research, particularly retention of data for possible publication. All data will be destroyed after publication.

3.4.2.2 Anonymity

Anonymity can relate to institutional and participant anonymity (Floyd and Arthur 2012). These authors argue that institutional anonymity is meaningless for insider researchers as publication under the researcher's own name will inevitably reveal the institution or organisation where they work(ed). They suggest therefore that the researcher should assume that organisational anonymity cannot be achieved, and emphasis should be on protecting the identity of the participants.

Participant identification needed to be considered at two levels: internally (within the service) and externally. External identification of participants was easier to prevent by changing any identifiable factors in the data generated. Internal identification, that is, mutual recognition of staff during the project was much more difficult to prevent. This was acknowledged with staff at the start of the project and clarified in the consent and information sheets that all data were shared unless the participant withdrew. The online survey did not ask for details that could identify participants therefore this was anonymous.

3.5 Data generation methods

3.5.1 Online survey: – the survey was built using Jisc Online Surveys (formerly Bristol Online Surveys) platform. A preliminary version was piloted with a small number (eight) of staff from other allied health professions within the organisation, particularly focusing on coherence, length and time required for completion. Following feedback received, the questionnaire was revised in collaboration with the researcher's supervisors. The questionnaire was informed by the AI literature. The qualitative sections explored the same themes as the workshops and again utilised positive questions about practice, explored values and beliefs and asked for patient stories, including exploring the effect of Covid-19 on PCC in SLT practice. The quantitative data was mainly demographic in nature (8 questions) with an additional 2 questions asking for ratings of factors which could influence PCC in practice. The survey questions (21 in total) comprised a combination of closed and open free-text boxes for elaboration (see Appendix 5). It was envisaged to take no more than 30 minutes to complete and was distributed via SLT professional clinical networks.

3.5.2 Electronic diaries: - Prior to each workshop each individual participant of each clinical team was asked to record an electronic diary for one month, reflecting on person-centredness in their clinical setting. This diary took the form of a team folder on the SLT shared drive on the health board IT system, where it was possible to create individual folders if needed. Each team had a separate folder (a total of 5) with a password shared only with the researcher. The researcher provided a few key questions to promote reflection but otherwise the content indicated the participant's personal understanding of the concept of person-centredness. Staff were asked to continue with the diary for an additional month after completion of the workshop to evaluate if different parameters of care and intervention were recorded following participation in the workshop. However, due to work pressures secondary to Covid-19 only one clinical team completed two diary cycles, and only one diary extract was used in the final thesis.

3.5.3 Staff workshops: - Each workshop followed a set format and took three hours. They were held in a setting chosen by the clinical team, at a time and date convenient for them. This date was dictated by staff available to cover clinical work and needed careful planning due to Covid-19 pressures impacting on numbers of available staff.

The start of each workshop involved setting the scene, explaining the approach and expectations and revisiting consent. Prior to commencement of the appreciative dialogue two other activities were carried out, based on imagery and metaphor, in order to draw out values and beliefs and encourage generativity. These activities were done as a group.

Rather than using generic pictures, staff were asked to bring with them to the workshop either an object or picture of something that represented person-centredness for them. The explanations of these objects and images gave staff an opportunity to see and discuss their work in a new way as each object or picture was very different. Each description was also highly personal and hopefully reflected a safe space felt by staff within the workshops. Prior to each workshop participants were informed there were no right or wrong choices of picture or object, as expression of vulnerability and authenticity has been associated with visual methods in the academic literature (Roddy et al. 2019). Visual inquiry is a method particularly relevant to research concerned with practice development, as it not only opens up discussion but may reveal tacit knowledge; it is also a convenient method for novice researchers or novice facilitators (Roddy et al. 2019).

The second activity presented person-centred practice as a metaphorical cake with many ingredients. Discussion of these 'ingredients' revealed what staff believed were the essential values and elements of person-centred practice.

The final workshop activity consisted of the AI 4 D cycle procedure:

Discovery phase: - participants in each group were asked to pair up with a colleague and recount a patient story, which in their view reflected person-centred practice, to their partner. Each 'interviewer' wrote down their colleague's story. Subsequently all participants linked up with the group to share the highlights of their stories and extract common themes. A worksheet of positive questions (see Appendix 6) was provided by the researcher for this purpose. Extraction of themes was facilitated by the researcher and recorded on a flip chart. From this point onwards the participants worked together as a group, and this was also audio-recorded.

After all stories had been shared and themes extracted, the group was asked to choose one story that best exemplified the topic of person-centredness. The attributes presented in this story represented the "positive core" which formed the foundation of the next phase (dream).

Notably, given that stories are often conflicting and contested, and can include negative aspects or those that are critical of an institution or its service (shadow – see section 3.3.5) I had decided that what was deemed positive would be on the basis of agreement of the group. It might be that the core story was entirely critical, but that the group decided that learning had occurred. I did not intend to reshape stories that the group presented, but rather there would be opportunity for an appreciative discussion to reflect on how each story was chosen and why. The next part of this Discovery stage involved identifying opportunities for change, which could include an appreciative way forward regarding any 'shadow' material that had arisen.

Envision (Dream*)* phase: – using the data from the previous phase, the group was invited to project into the future when their everyday clinical practice would be underpinned by the 'positive core'. This phase considered what things to keep, and what they wanted more of.

Co-create (Design*)* phase: – this phase concerned planning how their ideal service could look and suggestions for ways forward.

Embed (Destiny) phase: – this stage as it is normally presented in the literature involved thinking about what is needed to enable and sustain change. This stage was planned as an 'inter-stakeholder' group drawn from representatives across the whole service, where the data generated and categorised in the first phases (Discovery/Dream/Co-Create) could be reviewed and reflected upon. At this point also any changes in practice instigated by staff in the period between the phases could be evaluated before feedback to the rest of the service. However, although the study had been planned prior to the pandemic, data collection took place during the waves of the Covid-19 pandemic itself which ultimately impacted on the timing of the workshops, accomplishment of the different AI stages and momentum of the study. For example, due to ongoing severe workforce pressures secondary to Covid-19, the cross-settings workshop (as part of the Embed phase) did not take place. This effectively resulted in a project that was 'incomplete' and less collaborative than initially planned and did not align with a 'true' AI methodology.

3.6 Ethical considerations

3.6.1 Ethical approval

The study received IRAS ethical approval (IRAS ID 273293).

3.6.2 Study setting

This study was situated within the researcher's own SLT service, where the researcher was the Service Lead. It is a service for adults with acquired difficulties. The clinical specialities covered by SLTs in the service comprise both local and regional, tertiary specialised services. The SLT staff work across hospital, out-patient and community settings.

3.6.3 Risk of harm

It was not considered that this study had potential to cause harm to any participant**.** It was acknowledged that the researcher held a position of power and authority with regard to the other participants within her own service. This position had potential to generate particular ethical dilemmas which are explored in section 3.7.

3.6.4 Dealing with emotions.

Latchem-Hastings (2018), in research on the values of paediatric physiotherapists, discusses emotional issues that can arise during insider healthcare research, such as revealing emotions related to recall of sensitive professional experiences. My project also had potential to unveil upsetting scenarios for staff. It was essential therefore that staff were signposted within the information sheet to internal support systems available within the health board and that participants felt able to withdraw with no professional repercussions. In addition to emotions generated by recall of clinical stories, this study took place during Covid-19, a time when staff were particularly fatigued, with the potential for heightened emotional reactions. Information regarding availability and access to potential internal support mechanisms and wellbeing fora was especially pertinent.

3.7 Insider research

It has already been acknowledged that the researcher was in the position of 'insider' in this project, posing its own particular ethical dilemmas. Floyd and Arthur (2012) suggest that insider researchers, particularly those researching their own practice, such as professional doctorate students, need to consider both external and internal ethical engagement (see Figure 4). The authors argue that data collection may pose internal ethical dilemmas which include:

> The below-surface, murky issues that arise during and after the research process linked to ongoing personal and professional relationships with participants, insider knowledge, conflicting professional and researcher roles, and anonymity.
>
> (Floyd and Arthur, 2012, p. 172)

The dilemmas listed above are now discussed in more detail.

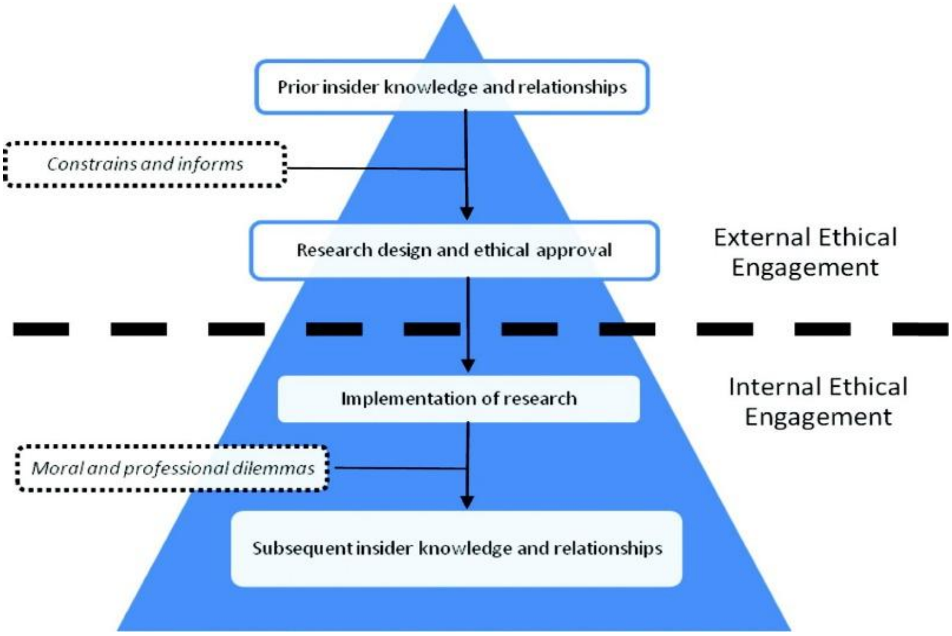


Figure 4: External and internal ethical engagement (Floyd and Arthur 2012, p.172)

3.7.1 Relationship issues

The unique nature of insider research means that research participants could work alongside/under the researcher for some time after the research project itself had concluded. This could result in a situation, for example, where knowledge uncovered during the research could become problematic either during the project itself or even after it had been completed (Drake 2010). The knowledge uncovered could relate to personal information about the participants or be concerned with their professional practice (professional practice issues are discussed later in this section).

Floyd and Arthur (2012) describe these issues as belonging in the domain of data ownership, with the need to also consider how that data is eventually used. One suggestion by the authors is to send each participant a copy of any interview transcript and ask for comments. Since the data in this project was co-produced throughout the project, each participant was well-informed at the end of each workshop as to the content and use of the data produced. I did, however, re-visit consent to share the content of each separate workshop with other staff members. This was done during each workshop and would have been repeated prior to the planned inter-stakeholder workshop.

3.7.2 Insider knowledge

Insider knowledge can relate to familiarity with the wider organisation, service or practice being researched, or all of these. Floyd and Arthur (2012) suggest that an insider researcher should consider whether it is ethical to use insider knowledge to challenge or question a participant's contribution: potential psychological harm to a participant should be avoided at all costs. Dewar (2011) however, considers that insider status confers advantages related to access to information and participant engagement which may not be available to a researcher with 'outsider' status.

Hayfield and Huxley's (2015) publication on insider/outsider research reminds us that insiders need to be wary of pitfalls during data collection and analysis, such as assumptions of shared understanding or disregarding aspects of the data. This is explored further in the section on researcher subjectivity (see section 3.7.4). Hayfield and Huxley (2015) also comment that a researcher can be both insider and outsider when characteristics such as gender, sexuality, class or age are considered. In my study, although I identified with 24 of the participants regarding gender (there was one male SLT), I was the eldest person by far in three out of the five workshops. In these three workshops I also had many more years of clinical experience and organisational knowledge than the staff participants: I identified as insider through being a SLT and being inside the healthcare organisation.

3.7.3 Professional and researcher roles

Due to role duality, there was potential for tension between these roles during the study. Any concern by participants about potential judging of practice and the researcher role needed to be clarified at the outset. However, if exploration of practice revealed elements that conflicted with accepted professional practice, then I needed to consider how to deal with such issues. This is particularly problematic in healthcare research where clinical practice affects the quality and safety of patient care. I was guided by HCPC's (2016) standards of practice and RCSLT's (2005) clinical guidelines and this was stated clearly in the participant information sheet.

3.7.4 Researcher subjectivity and reflexivity

Researcher subjectivity is considered integral to qualitative analysis (Berger 2015; Braun and Clarke 2022) as qualitative research is regarded as a subjective process where the knowledge created reflects both researcher and participants' values and assumptions:

> Reflexive research treats knowledge as situated, and as inevitably and inescapably shaped by the processes and practices of knowledge production, including the practices of the researcher. We therefore view researcher subjectivity, and the aligned practice of reflexivity, as the *key* to successful reflexive TA.
>
> (Braun and Clarke 2022, p.13)

Locating myself within the research process was therefore essential. The researcher impacts on the research design, data collection and analysis through their own personal and professional values and identity and influences the analysis accordingly. This is considered to be a key element of qualitative research and a valuable resource, but critical reflection on the researcher's role in production and analysis of that knowledge is essential. This critical reflection is termed reflexivity (Finlay and Gough 2003).

Reflexivity is a tool that is particularly important in qualitative research and reflexivity regarding researcher position is especially important in professional doctorate research projects due to insider positioning and the issue of familiarity (Delamont and Atkinson 1995; 2021). Berger (2015) defines reflexivity as:

> It means turning of the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effects it may have on the setting and people being studied, questions being asked, data being collected and its interpretation. As such, the idea of reflexivity challenges the view of knowledge production being independent of the researcher producing it and of knowledge as objective.
>
> (Berger 2015, p.220)

Whitaker and Atkinson (2021) discuss the concept of epistemic reflexivity and distinguish between its different types: positional, methodological and disciplinary. Positional reflexivity is concerned with how the researcher's values and biography influence the knowledge produced, methodological reflexivity relates to the methodology and the study design while disciplinary reflexivity is connected to academic or professional background and how this may frame or constrain research topics and methodologies.

> The principle of epistemic reflexivity acknowledges that knowledge-production is grounded in multiple relationships and engagements that encompass the researcher and the research participants, the researcher's community of practice, and networks of technique and method.
>
> (Whitaker and Atkinson 2021, p. 65)

Regarding positional reflexivity, I have previously remarked (see section 3.7.2) on how I identified with the staff participants regarding gender, age and clinical experience. Whitaker and Atkinson (2021) however, assert that positional reflexivity goes beyond the researcher's personal biography and that power needs to be included in discussions of positional reflexivity. I have already commented on the aspect of power and possible tensions between my roles and relationships in section 3.7.3 of this chapter when I argued that any 'unprofessional' practice uncovered during the staff workshops would need careful and sensitive handling. The participant information sheets emphasised that I was adhering to our regulatory and professional standards concerning professional practice knowledge discussed in the workshops.

My own values aligned greatly with person-centred care and during my time of clinical practice I would always strive to work in this way, although a review of my reflections at the start of my research process show how much I questioned this concept while appreciating its diversity in understanding and practice. I constructed the research based on significant personal and professional investment in the research question(s) and had read widely concerning the topic. I therefore approached data collection and analysis with genuine curiosity. Whitaker and Atkinson (2021) consider that insider research generates a particular kind of positionality, as the researcher is a member of the professional community or occupational group. In this instance, reflexivity relates to 'making the familiar strange' (Delamont and Atkinson 1995, 2021). In my case, I believe the methodological approach to my study helped to lessen familiarity.

Methodological reflexivity is concerned with how the research process and the method(s) chosen to collect and analyse data may influence the data produced. The online survey guarded against the researcher being familiar with the participants as all responses were anonymous. In addition, the SLT respondents worked in very different clinical settings, many of which I had not worked in on a clinical basis, with my knowledge of those settings being second-hand and more managerial.

I believe that the use of a visual method within the initial part of each workshop (the participants' objects and images) also helped to lessen familiarity (see Mannay 2010; Mannay and Morgan 2015), not only for the researcher but also for the participants. As Mannay (2014) suggests: "For participants, then, visual data production can be a process in which their …[practice is] reconsidered, re-evaluated and made strange" (p.9).

During data analysis and coding I found that my sense-making initially reflected my SLT background and disciplinary training, and it was only after several subsequent readings of the data and discussion with my supervisors that more sociological understandings developed. The study was designed specifically as a participatory project and the knowledge produced was collaborative although the interpretation reflected my subjectivity. The socio-ecological model as a lens to data analysis evolved through the process of the research and allowed me to view the data in a novel way.

Disciplinary reflexivity relates to how disciplinary knowledge influences what topics are studied or even excludes certain topics, based on areas of inquiry within the researcher's 'home' discipline. Prospective and novice researchers are influenced by key publications within their professional fields, which in turn can either constrain research ideas or promote certain areas over others (Whitaker and Atkinson 2021). These are further sustained through the methodological training that is endorsed or widespread within the educational establishments of that particular discipline or health profession.

Within SLT, Douglas et al. (2023) call for more participatory methods of research, where knowledge production is bi-directional between clinicians and researchers:

> This [American educational system] establishes a norm that knowledge production and dissemination is unidirectional, from researchers to clinicians, for the purpose of clinicians consuming and implementing that research without the input of clinician-initiated needs or questions.
>
> (Douglas et al. 2023, p. 805)

Integration of clinicians into the research process, as in my study, ensures that practice realities are realised, and that the knowledge produced has real-world significance, both for clinicians and patients. Connery and Salsberg (2024) concur that there exists a research-practice gap in SLT and demand more participatory approaches, such as participatory health research (PHR), which can include not only clinicians but also patients:

> PHR provides an alternative research avenue for the discipline of SLT, a discipline that remains dominated by an efficacy evidence base that often lacks relevance to real-world contexts. PHR values other forms of evidence generated from key partners (e.g., people with communication disabilities or SLTs), and it is this local knowledge that is essential in the development of effective and sustainable interventions.
>
> (Connery and Salsberg 2024, p.3)

The AI approach that I adopted in this study allowed co-creation and generation of knowledge that is localised but also of interest and usefulness to SLTs across clinical settings. My insider knowledge allowed exploration of a topic that is not only under-researched within the profession (Forsgren et al. 2022) but according to the online responses, it is a topic participants felt should be investigated.

Disciplinary reflexivity also concerns interrogation of “disciplinary values, assumptions and norms” (Braun and Clarke 2022, p. 270) which colour and influence analysis and interpretation of data. I found reflexive journaling helpful as well as reading examples of journal articles reporting use of Reflexive thematic analysis. Regular supervision provided externally to my own organisation, that is, by Cardiff University, greatly aided my reflexivity through helping me to extend my thinking about the data.

3.8. Data Analysis

3.8.1 Approach to analysis.

The study is a mixed methods study but is qualitatively driven (see Frost et al. 2022). The quantitative aspects of the online survey mainly involved demographic data which served to supplement the qualitative elements of the survey. The narrative responses to the open questions in the survey were analysed in the same way as the workshop data.

The choice of analytic method was based on the values, assumptions and practices of ‘Big Q’ qualitative research, namely that the knowledge created is situated and contextualised, and researcher subjectivity is a vital component, acting as both a resource and an influencer who shapes the research (Braun and Clarke 2022). It also needed to align with the theoretical background to my study.

Reflexive thematic analysis (RTA) is a flexible method which can be used within a range of theoretical and epistemological frameworks (Braun and Clarke 2006; 2022). It is utilised across a wide range of disciplines such as healthcare, social sciences and beyond to analyse qualitative data sets generated by a variety of data collection methods and address diverse research questions. The aim of RTA is to develop themes or patterns of meaning across a dataset. Braun and Clarke (2006) assert that in contrast to other analytic methods which aim to generate patterns across data, such as interpretative phenomenological analysis (IPA) and grounded theory, RTA is not bound to any particular theory. RTA is an analytic method which is compatible with my study with its constructionist and interpretative framework.

Development of themes is typically done by familiarisation with the data, followed by coding, development of initial themes and finally revision of themes. Coding and analysis were guided by Braun and Clarke's (2006; 2013; 2022) recommendations for undertaking RTA. I checked the transcripts against the audio- recordings and read the interview transcripts several times to familiarise myself with the data, while making notes in the margins of comments or dialogue I felt were significant. I initially did this for each transcript separately. The same process was followed for the narrative data associated with the visual images and electronic diaries. As the workshops took place over a period of several months (due to Covid-19) and since transcription was undertaken by an outside agency, there was often a long gap between receipt of transcripts. Once all transcription was completed, I looked across all transcripts for obvious patterns. The qualitative questions in the online survey were analysed similarly and ultimately collated with the workshop data.

The next stage involved generating codes which denoted any data relevant to the research questions. Since person-centredness is an under-researched area within SLT, I decided to look across the whole data set for themes, instead of focusing on one theme or a group of themes in detail. I wanted to identify the predominant themes through a rich description of the data set, followed by a deeper, interpretative analysis. The initial inductive approach to analysis and how I viewed the data reflected my SLT background and my personal interest in the topic; coding generally occurred at a descriptive level. Several rounds of reading the transcripts and discussion during supervision sessions were required to code at a deeper level. This was still data driven and I constantly tried to relate back to my research questions. Analysis was a recursive, iterative process where themes evolved and changed over time.

During this process of immersion in the data it became evident that the patient's social connections and relational aspects of practice were important to SLTs. Discussion of the data with my supervisors also drew attention to the use of metaphors by the SLTs in the workshops, in particular ecological metaphors. In order to draw out further these relational aspects I decided to adopt a socio-ecological model (see Figure 5) to extend the analysis and thus a further research question was generated (RQ2).

Use of the socio-ecological lens for data analysis resulted in more theory-driven analysis, especially as my reading of the literature developed and added another layer to the analysis. The next section discusses the SEM in more depth. This additional analysis developed the biosocial/biocultural themes underlying the data. Data analysis continued cyclically with a process of inductive and deductive approaches.

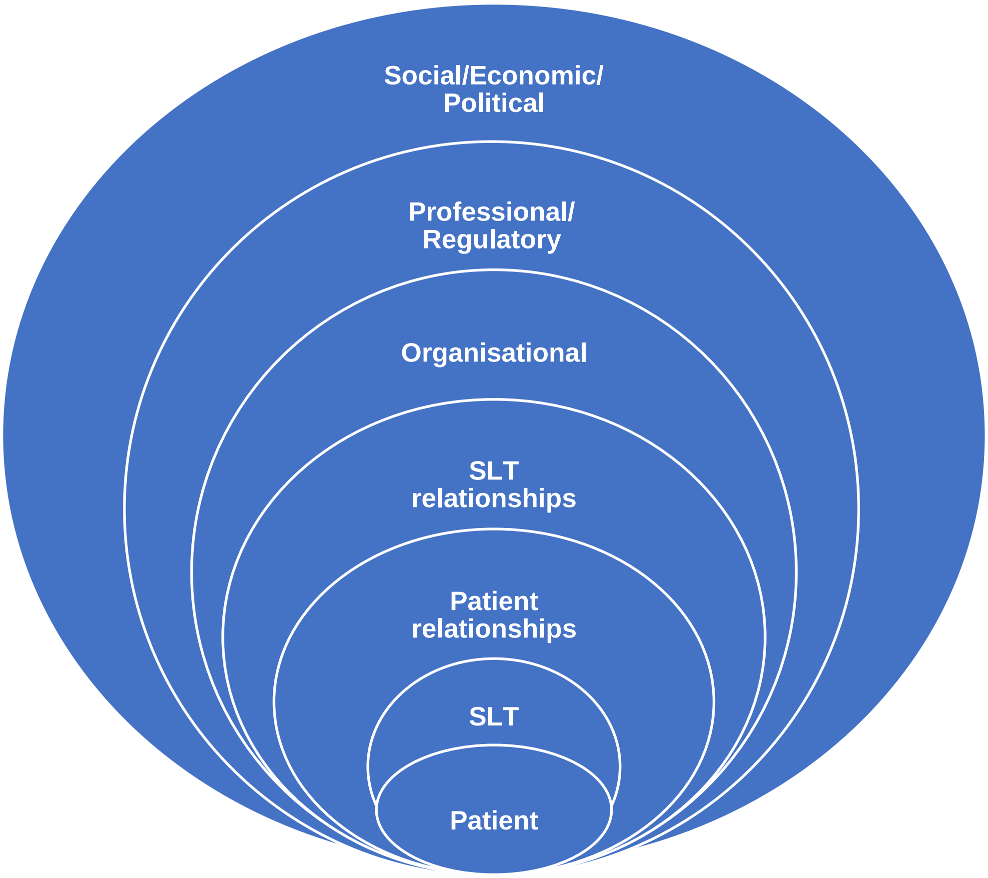


Figure 5: Socio-Ecological model (adapted from Davidson et al. 2018)

3.8.2 Socio-Ecological Model

As mentioned previously, the ontological underpinning for the chosen methodology is based on thinking about person-centredness as a relational construction, shaped by particular relations that are evident to the SLTs in their practice. The SEM adopted for this analysis is based on Davidson et al.'s (2018) adaptation of Bronfenbrenner (1979) (see Chapter 2, section 2.12.2) and is used to extend the biocultural approach to the analysis with the aim of reflecting the person as both a material and social being.

The model allows exploration of factors impacting and influencing many different microsystems within the same level. The same is true of the organisational level, where a microsystem exists between SLT and organisational values and drivers. Davidson et al.'s (2018) adapted model is used here since it illustrates the influences which impact not only on the patient, but also on the SLT i.e., personal and professional drivers both come to the fore. I have changed the terminology from 'nurses' to SLT.

When the SEM is combined with a systems-thinking approach (Meltzer and Muir 2022), two additional concepts of 'feedback loops' and 'levers of change' can also be employed. Feedback loops are described as circular relationships, where one element affects another (or multiple elements), and consequently, this outcome produces a further action from the first element via a feedback loop. An example of this might be where a reduction in the budget of a SLT service may result in reconfiguration and unavailability of certain clinical services due to SLT vacancies being frozen as part of a cost reduction method.

A 'lever' is a place within the system that enables an actor to produce change in the system, for example by breaking negative feedback loops. Actors can be both patients and healthcare practitioners (HCPs). These two elements of feedback loops and levers therefore allow illumination of how SLTs effect change for their patients and others within their interpersonal microsystems.

Analysis of levels, relationships and processes is facilitated through use of the SEM in conjunction with systems thinking. Analysis which is underpinned by a constructionist framework enables surfacing of the sociocultural context which affects SLT conceptualisation and practice of person-centredness. Hersted et al. (2020) assert that the marriage of action research (and thus AI) with systems thinking reflects how people are irrevocably interconnected:

> Furthermore, relationships (among people or within and between systems) are crucial in systems thinking, action research and social constructionism as relationships based on communication are crucial to transform, improve and create sustainable and flourishing communities.
>
> (Hersted et al. 2020 p. 13)

3.9 Introduction to results

Although this is a methodology chapter, some results are presented here as they pertain to the demographics of the research participants. The analysis chapters which follow have a qualitative focus and I felt it useful to separate the two elements, especially as the demographic information is not extensive enough for a separate chapter.

3.9.1 Clinical settings and participants' demographics

Online survey

Overall, 80 survey responses were received. All respondents answered questions on demographics or those requiring yes/no responses. Where respondents were invited to provide free-text comments, between 79% (n=63) and 95% (n=76) of the sample took the opportunity to do so. Most respondents (84%) indicated working in the NHS, while others worked in either non-NHS settings (11%) or both (5%). Clinical settings were divided approximately equally between primary and secondary care. A very small number (n=7) worked in specialised settings such as hospices (n=2), mental health (in-patients and community n= 2), higher education (university - n=1), palliative care (n=1) and schools (n=1).

The respondents' years of experience ranged from 2-5 years (14%), 6-10 years (21%) and over 20 years (40%). Their age varied from 21-30 (21%), 31-40 (25%), 41-50 (24%), 51-60 (26%) and 61-64 (4%). The majority (65%) worked in England, while 19% worked in Wales, with less than 10% working in Scotland and Northern Ireland.

Speech and language therapy is a female-dominated profession, and this is reflected by 98% (n=77) of the respondents identifying as female, 1% male and 1% as non-binary.

Staff workshops

There was a mix of ages and experience although the workforce as a whole was younger than those online with 19 (76%) either aged 21-30 (28%, n=7) or aged 31-40 (48%, n=12) (see Table 7). The distribution of staff participants contrasts with online respondents as their numbers were quite evenly matched in all four age categories between the ranges 21-60. Years of experience of qualified staff in the workshops were mainly between 11-20 years (44%, n=11)) with only 3 SLTs (12%) working for over 20 years. This is a significant disparity with the online respondents where 40% placed themselves in the category of 20+ years of experience.

Table 7: Staff participants' demographics

Staff participants (pseudonym)	Sex	Age range	Years of experience
Katrina + Joyce	F	51-60	20+
Sadie	F	41-50	20+
Sharon, Sabrina, Rachel, Stella, Nadia, Tara, Carol, Nancy, Elaine, Eva,	F	31-40	11-20
Lily	F	51-60	11-20
Enya	F	41-50	6-10
Siobhan	F	31-40	6-10
Katy, Mark	F, M	21-30	6-10
Charlotte	F	41-50	2-5
Laura, Helen, Odette	F	21-30	2-5
Ava	F	21-30	1-5
Fran	F	31-40	2-5 (support staff)
Anne	F	21-30	2-5 (support staff)

3.10 Organisation of the analysis chapters

The following four analysis chapters are organised according to the levels of the SEM i.e. intrapersonal, interpersonal (patient), interpersonal (SLT) and organisational. I am presenting an integration of the data across the workshops and online survey.

Intrapersonal level

Chapter 4: SLTs' relational conceptualisations of PCC and how their values shape their practice.

Overview

This chapter begins with an overview of the analysis and the themes generated, before moving on to the intrapersonal level of the SEM (introduced in section 2.12.2 in Chapter 2). This level introduces the SLTs' individual conceptualisations of person-centredness.

Socio-ecological models of healthcare emphasise multiple levels of influence which are constantly interactional (Golden and Earp 2012). They are essentially composed of horizontal and vertical relationships between myriad microsystems and levels, all of which inter-connect and influence each other. As the analysis progresses throughout the thesis, it becomes evident that each level does not stand alone but interfaces with and impacts on the ones above and below.

As elaborated in Chapter 3, to guide analysis and surface the elements of SLT practice, a social-relational lens, in conjunction with the tools of a socio-ecological framework and aspects of systems thinking, is employed. This analysis shows how the professional discourse of SLT aligns with socio-ecological thinking within the social and health sciences to surface these socially informed understandings about the practice and concept of person centredness, focusing on patient needs within relationships and everyday interactions and practices.

Within this chapter I present analysis of qualitative data generated from open comments in the online survey combined with staff narratives and visual imagery from the workshops (see Methodology chapter).

This chapter links to research questions 1 and 3:

RQ1: What is SLTs' role within person-centred practice and how do their values shape their practice and professional identity?

RQ3: How can a socio-ecological framework contribute to our thinking on PCC within

SLT clinical practice?

4.1 Overview of themes

Three themes are generated and discussed in detail in this thesis:

1. **Biographical reconstruction**, comprising work by SLTs on reframing patient identity and maintenance of every-day routines and social practices**;** it includes the idea of the patient *becoming other* through SLTs' work on communication and identity.

2. **Materiality of care**: elements of everyday life, such as objects and food become part of SLTs' work in supporting patients to re-build relationships and social roles.

3. SLT working as a **social bridge** with family, a role that became more obvious during Covid-19.

These themes are illustrated in Figure 6, which shows how each theme links into the overarching theme of **relational recovery**:

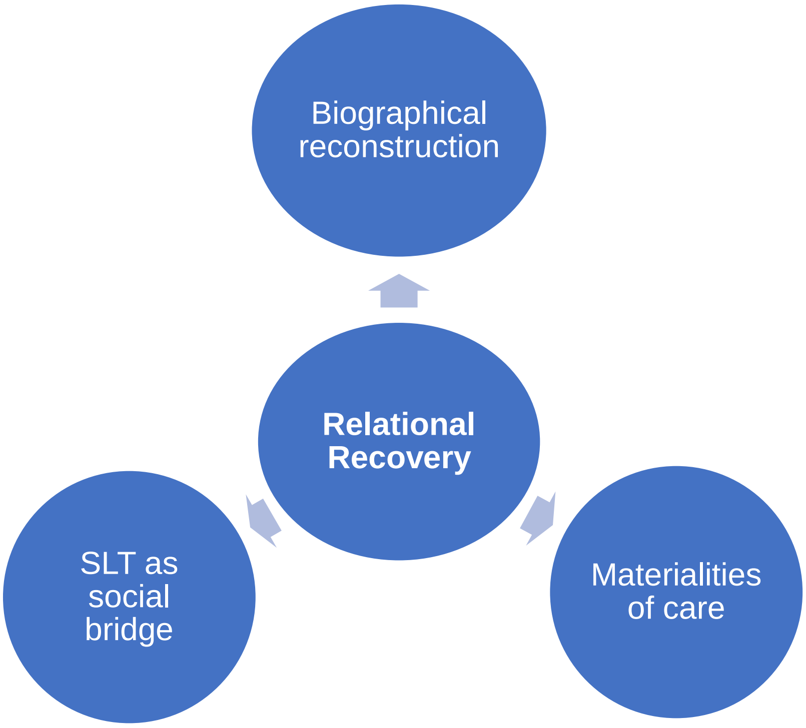


Figure 6: summary of themes generated.

The themes highlight that SLT intervention, focused primarily on relationships, may be considered to be biocultural (Wiley and Cullin 2016) in that it links together physical factors, psychological elements, and social or cultural context.

Each analysis chapter is configured slightly differently. For example, this chapter, as an introductory chapter to the data, is lighter in its use of theory. I introduce relevant theory towards the end of Chapter 5 while Chapter 6 begins with an overview of theory employed.

This chapter focuses on the intrapersonal level of individual SLTs, by exploring SLTs' use of metaphors to present individual understandings of PCC and how their underlying values shape their conceptualisations of person-centredness.

4.2 Metaphors that conceptualise PCC, and relationships and values that matter to SLT.

In this section I discuss how the individual SLTs construct person-centredness through their use of metaphor and what this reveals, not only about their understanding of the concept but also which professional and personal values underpin this understanding. I present individual SLT reflections rather than an integration of them to demonstrate the diversity of thinking by the participants surrounding the topic.

4.2.1 Metaphors based on non-clinical images or objects.

The SLTs attending the workshops were asked to bring with them an object or image that represented PCC for them. SLT clinical work utilises pictures and objects as part of the assessment process, therefore using objects to generate discussion was, in one way, familiar to the participants. It was also a way of encouraging participants to think about the topic slightly differently (i.e., making the familiar strange; see Chapter 3, section 3.7.4).

The SLTs in my study used metaphors to illustrate their perception of person-centredness and some examples are presented below. Lily chose an image of a fox:

My thoughts around person-centredness as a SLT were driven by the desire to convey the purposeful vigilance aimed at being aware of the person's individual needs. For this one must be present, and alert to the other's situation, and alert to their needs and desires.

I chose a fox as a being that is known to be alert and vigilant, reliant on skills and instinct, with the physical attributes of acute senses.

Figure 7: Lily's image, workshop 3, stroke rehabilitation.

Lily's comments, particularly her use of the metaphor 'one must be present' reveal how total engagement with the patient and use of all senses by the SLT, for example 'active listening,' is necessary to unravel the patient's story and learn about their circumstances. Espie et al. (2021) assert that HCPs need to "engage meaningfully and effectively" in order for their practice to be person-centred, and this requires them "to have some understanding of where the other person is coming from and what matters both to [the HCP] and to them at that time" (p.122).

Lily's fox image also conveys the idea of the SLT as a 'hunter', not in the sense of perceiving the patient as prey, but in the sense of 'hunting for clues' about the patient as person in their particular environment. Lily's choice of vocabulary such as 'alert', 'purposeful vigilance' and 'instinct' reinforces the conception of SLT as a tracker who is actively seeking out signs and hints in order to get a full biosocial/cultural portrait of the patient.

The emphasis on context also appears in Rachel's picture of a tree. Her explanation illustrates underlying appreciation of patients' individual needs while recognising their deep connections to family and wider community. The possibility of change over time and the need for ongoing support is also reflected in her narrative:

Every tree is unique and will only flourish and become 'the tree it can be' if we truly understand its needs at any time. A tree will look very different throughout the year/seasons and different conditions may shape its appearance, but if we know the key values/needs of that tree, we should be able to well support it throughout its different states. Also, a tree is rooted in the place it belongs and knowing that context is essential

Figure 8: Rachel 's image, workshop 1, brain injury rehabilitation.

Metaphorical thinking is developed further by the snowflake which represents person-centredness for Nadia:

I chose a snowflake to represent patient centred care because every snowflake is different although can seem similar to the naked eye – e.g. with stroke even if patients present with a similar stroke and their deficits are the same, we must respect that every person is different and will still have individual needs.

Figure 9: Nadia's image, workshop 3, stroke rehabilitation.

The metaphors utilised by the SLTs in my study illustrate that they perceive the patient as unique and individual but also existing in a network of relationships and connections, which are vital to include in SLT intervention. The networked relationships discussed in the explanation of their images show the importance to the SLT of the patients' close and distant associations and bonds, within families and significant others or wider into the community:

> Being able to appreciate the patient within their context, within their community. So, the person within their village so that you can truly appreciate their life, their values and what else they want.
>
> (Sharon, workshop 1, brain injury rehabilitation)

> To offer person centred care you need to consider the whole context, and it can't just be looking at the individual.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Thus, it might be possible to suggest that the SLTs are seeing the person as a social-relational being, embedded within networks and communities, from the beginning of the episode of care. This recognition of context, and issues which are wider than medical issues, are regarded by Kogan et al. (2016) as characteristic of holistic care wrapped around the 'whole person' and essential to person-centredness. This is echoed in the online data:

> Person-centred care puts people, families and the communities at the centre of the health, care and wellbeing plans.
>
> (P61, online survey)

> Should be configured to deliver what matters to the individual within the context of their community.
>
> (P46, online survey)

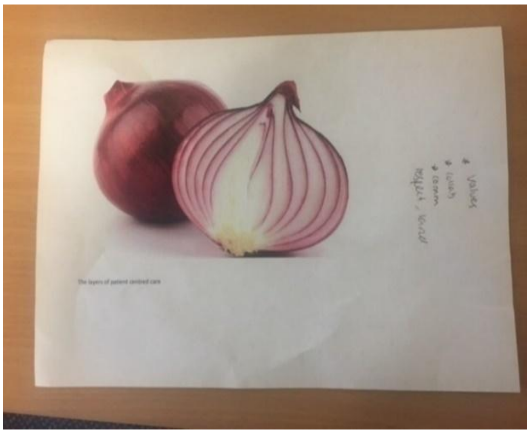
The idea of a network resonates with Stella's image and accompanying narrative which conveys a principle of collaboration, which is developed further in the explanation of the image. Stella portrays the SLT as both guide and facilitator, indicating a more equal relationship where the patient is not disempowered:

This image symbolizes 'collaboration' which for me is what underpins person centred care.

Being patient centred involves open, two-way communication, active listening, working together with the patient to identify relevant goals that are meaningful for the patient, listening to what the patient wants and acting on this rather than what we think they should have or do. PCC also involves being respectful of the patient's wishes and considering their needs/desires and values in everything that we do. I feel this symbol fits well with the idea of guiding and supporting the patient through their intervention by placing them at the core of everything we do.

Figure 10: Stella’s image, workshop 2, outpatients.

Collaboration and communication with patients and families were regarded by staff as vital to PCC, for example Laura’s choice of an onion. The layers inherent in this image demonstrate the multiple facets of person-centredness, which Laura distinguished clearly from a biomedical approach:



I brought along an onion, and I picked an onion because, I guess, to represent all the different layers of patient-centred care. We do focus quite often on the medical side of things and what needs doing there and then, but it's the little things like you touched on then. So, it's like collaboration often between us and the family and the patient. The communication. So, I've just picked that because I feel like there's lots of different layers to patient centred care and for each person, I think it's different

Figure 11: Laura's image, workshop 3, stroke rehabilitation.

Collaboration, communication and time are prioritized by Siobhan as key enablers which allow the SLT and patient to co-construct the patient's clinical priorities. Siobhan's comments equate time with SLT facilitation of communication and thereby the discourse of an agentic and empowered patient. Patient agency via shared decision-making and co-production are evident in the literature on centredness in healthcare (Waters and Buchanan 2017; Sturgiss et al. 2022).

The object I chose to bring was a clock, as I believe the concept of time represents person-centredness. The idea of person-centeredness is to consider the individual's own values, beliefs and motivations. By ensuring that the individual is given the time needed to express these opinions, we can ensure that the person is put in the 'middle' of their therapy and can make their own decisions and develop their own goals

Figure 12: Siobhan's image, workshop 4, acute wards.

These images reveal that relationality is foregrounded in the SLTs' constructions of PCC. While the images initially look static, the explanations about them explore a number of social relations which serve to animate the connections which exist within and across the patient's interpersonal systems, such as those with family, friends or community associations. The metaphors act as “mini-narratives” (Mottier 2008, p.191) and create “a catalyst for deeper understanding” acting as “both a thing and a process; both that which is magnified and the magnifying lens” (Bleakley 2017, p.5).

The metaphors highlight the SLTs' underlying values of collaboration, respect for patients' individualism and uniqueness while also recognising their wider social context. The metaphors used by the SLTs emphasise relational and collaborative practice with the patient positioned centrally in their webs of relationships. These metaphors themselves act as scaffolds or bridges “which bring together two un-seemingly connected ideas thus creating relationships” (Schwind 2009, p.18). Associations and connections between people, work colleagues or even places are therefore emphasised.

As different metaphors reflect “differences in views, challenges and needs” (Demjén and Semino 2016, p.390) it is vital to listen to the metaphors used by patient and family to appreciate their perspective i.e., a “blended metaphoric space” (Bleakley 2017, p.171 drawing on Fauconnier and Turner 2002) needs to be created. Lily alludes to awareness of covert meanings in her narrative concerning the fox image:

> This may involve going beyond the overt and concrete things that one can identify (e.g., speech/language/swallowing ability, physical presentation) but to identify what else is happening for the person. This may involve subtle changes in mood, discomfort that is not readily noticeable, and concerns that have not been overtly voiced (whether that is due to the impairment, or due to lack of confidence to indicate worries). In being alert for physical and non-physical discomfort, we are in a position to respond to what is noted.
>
> (Lily, workshop 3, stroke rehab)

Lily suggests that SLT is mindful that to obtain a full picture of the patient's needs, the clinician must go beyond the physical presentation and stay attuned to subtle indications of other needs. These needs span social/cultural as well as medical/biological elements and thus SLT strives to incorporate all domains of the patient's microsystems in their evaluation and intervention.

The online survey data also reflects the idea of a network and the need for SLT to engage with all concerned:

> [PCC] puts the person at the centre of what you do - their character, their goals, their needs. It may merge into relationship centred care especially as we are looking at communication and we need to look at dyads and triads - whoever are the communication partners.
>
> (P4, online survey)

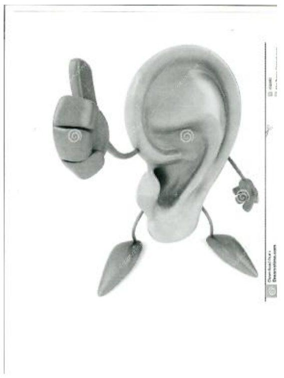
> The client is seen within their communication network at all times. Usually this involves the partner, but may include wider family, friends or work colleagues.
>
> (P52, online survey)

Dhand et al. (2016) recognise that “every patient is embedded in a complex and diverse social system” (p.604) and advocate that healthcare workers (physicians in this case) engage with the individuals identified as significant others within that person’s social web. It is recognised within health literature that positive social connections or networks influence health and wellbeing and can aid recovery and adjustment from illness or life events like stroke or brain injury (Holt-Lunstad and Smith, 2012; Holt-Lunstad et al. 2015; Hooker et al. 2020).

4.2.2 SLT professional tools as metaphors

This section continues the discussion surrounding metaphors. It is presented separately from the previous section as the objects and images provided by staff are part of the SLT’s professional toolbox and thus their practice. SLT practice uses several tools to facilitate communication. Here the participants’ descriptions of the SLT tools help us understand how and why communication is important in PCC, and what elements of communication, in addition to the elements described above, are relevant to SLTs.

Strong and Shadden (2021) equate listening with “truly one of the most powerful tools a clinician has” (p.116). Extraction of the patient’s narrative or “listening to the patient’s story” (P4 online survey) is identified as vital in the clinical encounter. Active listening was highlighted by Stella (see Figure 10) and is also identified by Joyce as a key tool for person-centredness. The SLTs associate listening with a means of getting to know the patient, particularly their life journey, social and cultural context and values and priorities i.e., a biocultural approach to practice.



I chose the ear because it represents active listening to me. As SLTs we need to listen to gain trust as well as information, but we also need to listen to understand and get the complete message without judgement. We then need to reflect and share this information as appropriate to provide a service that considers all the patient's needs.

Figure 13: Joyce's image, workshop 2, outpatients.

The 'complete message' alluded to by Joyce refers to all aspects of the patient's story - clinical, social and cultural information in addition to the patient's perspective of their situation. In this way Joyce believes that SLTs are able to build a complete picture of the patient's life.

This focus on a whole life perspective comes to the fore in the brain injury workshop:

> So, the other things we talked about was thinking about the patient's life journey. … their childhood and that type of thing and how maybe their current situation fits into that context of their whole life and also identities. So again, going back to the values and the crux of who that person is […] and also being really holistic and having that whole 360 view of someone and their goals and their values and their sort of future and everything.
>
> (Anne, workshop 1, brain injury rehabilitation)

Anne informs us that the rehabilitation period is understood by SLTs to be only part of the patient's life journey, and the emphasis is not only on learning about the patient's past but also thinking about their future. Journey metaphors used in healthcare are posited to empower patients by providing a sense of purpose, control and companionship (Demjén and Semino 2016) and are generally perceived as positive metaphors. They may also imply growth and mystery where the destination is unknown (Semino et al. 2017).

The idea of a rehabilitation journey is echoed in Sabrina's explanation of her choice of object (also used as a clinical tool) to represent PCC:

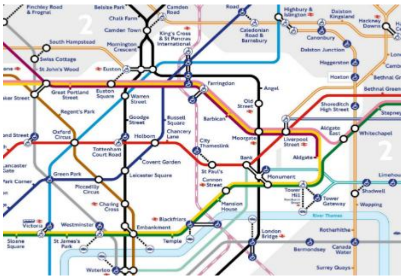
For me person-centred care is focusing on achievements and demonstrating the journey, starting at where they have come from and where they can go. Set through joint goal settings, using the patient's wishes and what's important to them. Also showing how they can achieve the next steps.

Figure 14: Sabrina's image, workshop 1, brain injury rehabilitation.

The SLT conceptualises their role in PCC as one of guiding and supporting patients regarding the best way of progressing through the rehabilitation process, as acknowledged by one patient:

> I found my way through the wilderness, but you gave me the map to show me the way.
>
> (Katrina, workshop 1, brain injury rehabilitation)

The wilderness metaphor used by the patient suggests exploration and uncertainty of direction, but SLT enables the patient to navigate the rehabilitation terrain/life post injury by providing direction and assistance. This metaphor frames SLT in a collaborative role where the SLT 'map' offers different routes or choices for the patient to consider. Sadie's choice of a tube map to represent person-centredness also presents SLT as a co-navigator with the patient:



I see the tube map as a representation of their journey in that there is a start and end point but lots of different ways of getting from start to end.

Figure 15: Sadie's image, workshop 1, brain injury rehabilitation.

SLTs' professional tools differ according to clinical setting and aims of therapy. For example, in the rehabilitation setting one of the tools utilised (Talking Mats) is considered by staff to progress the person-centred agenda:

> Talking Mats is a multi-use thinking tool which enables person-centred discussion where the listener (often you as a clinician) enables the thinker to express their thoughts/wishes/views to a given topic. Talking Mats ensures that we are actively listening to the person and that we give them space to consider their views and shape their own care. It enables individuals to have a voice where otherwise they may not – due to speech/language/cognitive impairment for example.
>
> It provides a space to learn about the areas of significance in a person's life in more depth. Whilst the idea is simple, the delivery is not simplistic. Talking Mats is the tool, but the skill is in preparing an individual mat that is asking the correct/most meaningful question and supporting the person to engage as fully as possible.
>
> (Sharon, workshop 1, brain injury rehabilitation)

Creating a communicative space with a mat not only makes visible the patient's values, concerns and wishes, which may then be shared with the rest of the multi-disciplinary team, but also repetition of the mat at regular intervals allows a record along a trajectory of progress, thus making the temporal aspects of rehabilitation more tangible. The mat becomes a marker of positive transitions along the rehabilitation journey.

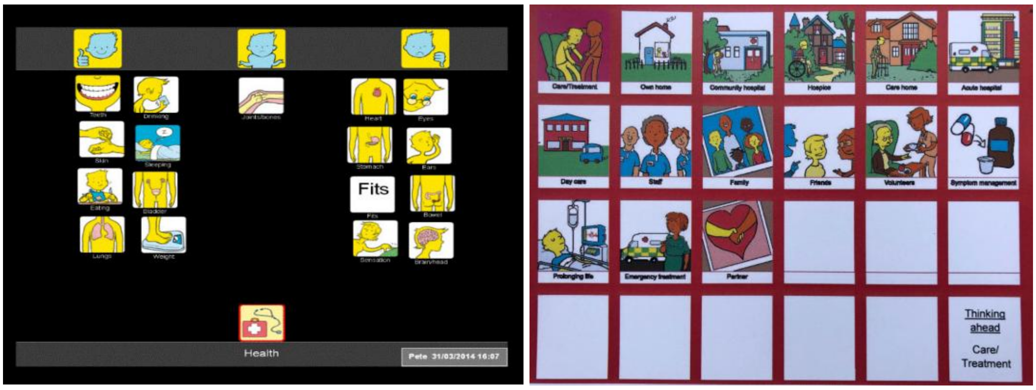


Figure 16: Sharon's completed mat (on left) with some of the pictures available from the Thinking Ahead pack of Talking Mats (on right).

Futures is therefore a feature of SLT tools. For example, the All About Me books which SLTs compose for their patients to aid communication (see Chapter 5, section 5.1.1) focus on life history and patients' relationships, while the rehabilitation journey metaphor and Talking Mats allow the SLT to work not only on current issues but also on anticipating futures with the patient. 'Mat talk' traces physical and cognitive-communication changes through time but also acts as a chronicle of the patient's concerns, issues and aspirations i.e., it mirrors the patient's identity as it is reframed.

4.3 SLTs' conceptualisations of PCC compared to other HCPs.

Metaphor use by SLTs has been previously explored in the context of caseload management (Kenny and Lincoln 2012) and aphasia rehabilitation (Ferguson et al. 2010). Metaphors may be considered as "reflections of the thoughts, understanding, and experiences of health professionals and their clients" but may also echo clinical experiences common to that professional workforce (Kenny and Lincoln, 2012, p.247).

Previous research into metaphorical expression by SLTs reveal use of metaphors related to sport, scales and war (Kenny and Lincoln 2012) and journey, battle and product (Ferguson et al. 2010). These metaphors provide us with a window on the socio-cultural meanings attached to SLT practice, from challenges inherent in caseload management in the former paper, to the experience of aphasia rehabilitation from the perspective of both SLTs and the person with aphasia and their significant other, in the latter publication.

Apart from the journey metaphor, the metaphors which come to the fore in my study differ significantly from these previous metaphoric expressions. The metaphors used in my study (for example, onion, clock, tree, handshake, ear, fox) disclose that the SLTs construct themselves as relational practitioners who prioritise knowing the patient and their connections, associations and relationships. The SLTs associate a person-centred approach to care with supporting the person's physical and socio-cultural growth and recovery. Other metaphors such as the snowflake reflects not only the patient's uniqueness but also how the pandemic influenced SLTs' conceptualisation of PCC such that its apparent fragility and tenuousness was highlighted (Chapter 7). The fox metaphor also illuminates SLTs' concerns regarding their own wellbeing during this time of crisis (Chapter 7).

Demjén and Semino (2016) remind us of the 'framing' power of metaphors in healthcare. For example, metaphors related to war and battle may reflect thoughts of conflict between patients and healthcare staff or highlight how patients and families perceive their experience of illness and healthcare provision. Metaphors inform the relationship between HCPs and patients and can convey emotions and identities (Appleton and Flynn 2014).

As I have already alluded, different healthcare professions may use different metaphors to represent their conceptualisations of clinical practice or even person-centredness. In the workshops staff felt that the SLT perception of PCC was not necessarily the same as that of other healthcare professionals:

> Our perception of person-centred care might not be what a nurse's perception of person-centred care is or an OT[7] or psychologist even, or physiotherapists. So, it's about collaborating as a team I suppose to get a common understanding or having those common processes that can lead to that.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Pedersen (2017) states that research into use of metaphors in healthcare interactions illuminate how certain professions work, as "metaphors interact not only with our understanding but also our actions and practice" (p.163). They reveal the professional

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[7] OT: Occupational Therapist.

culture underlying clinical practice, which, as discussed in Chapter 2, section 2.7, affects the person-centredness of staff (McCormack et al. 2021). For example, Bleakley (2017) discusses how master metaphors of ‘the body as machine’ and especially ‘medicine as war’ in medical consultations depict doctors as either mechanics who fix problems (i.e., they have the answers) or as heroes, thus creating “a culture that runs against the grain of the contemporary desire for a democratic, feminine, patient-centred and team-based culture” (p.35). SLTs’ metaphors and conceptualisations may therefore create tension with other HCPs’ ways of working, which is explored further in Chapter 6.

4.4 How SLTs’ values shaped their conceptualisations of PCC.

The previous section showed how SLTs’ values, particularly those of collaboration, engaging meaningfully and being aware of the patient’s whole life context were linked to their interpretation of PCC. I now turn to three particular values which were evident in the staff narratives, and I will show how these values further shaped SLTs’ conceptualisations of the concept.

Trust

Trust emerged as the primary and most important relation between patients and professionals. Trust for the SLTs is explored in the following section where I explain the characteristics given to it by participants – mutual and earned as well as the processes through which trust is shaped. I start with the mutuality of trust because it is a simple way of indicating from the start how trust is perceived as a relation – which gives it its character and at the same time is underpinned by the idea of a process of exchange between patient and SLT.

Terry and Kayes’ (2020) secondary analysis of three qualitative datasets of patients’ positive experiences of relational care emphasises trust as integral to the therapeutic relationship. Mutuality of trust (itself a relational value) is also portrayed as an element of building and maintaining the therapeutic relationship in my data:

> He’s been coming to us for quite a few months where we’ve been working on that therapeutic relationship, so he’s got the trust. So perhaps honesty and trust are an ingredient as well.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Staff consider that trust between SLT and patient is an element that needs to be earned by the SLT. This specific aspect of trust then configures SLT actions, for example, one way of earning trust is by accomplishing actions previously promised by the SLT as part of their key worker role in the rehabilitation setting:

> Tara: I'm just thinking about you Lily with your key worker role where you take personal responsibility to make sure things are done and you will make sure that that's kind of carried out.
>
> Nadia: And that builds trust which is another layer.
>
> (Tara and Nadia, workshop 3, stroke rehabilitation)

Joyce regards trust as a key element underpinning the clinical relationship, and one that needs to be built in the very first session to engage patients in their care:

> That's when you need to grab them and get their trust and get them to be on board with you because if you haven't got them there it's hard work or they DNA[8] or they don't want to come or whatever.
>
> (Joyce, workshop 2, out-patients)

Joyce's additional comment "we need to listen to gain trust" reveals how she associates person-centredness with an active process where building and establishing trust can be dependent on the deployment of other values such as active listening i.e., there is an ongoing process of working together with the patient by listening to their narrative. Active listening to the patient's story has already been aligned with person-centredness. Trust and active listening are highlighted as essential in getting to know the patient, which is key in PCC (Feldhusen et al. 2022).

Finally, trust in colleagues is also believed by the SLTs to be related to PCC. In the following extract, Joyce recounts a story where a co-worker's trust in the SLT resolves an issue concerning a patient:

> The healthcare support worker who came to you knew… that you would act on the information that she's given you. So, it's trust in your colleagues as well. If she couldn't do anything about it, then perhaps somebody could.
>
> (Joyce, workshop 2, out-patients)

The examples above demonstrate how SLTs' value of mutuality of trust enacted a specific professional approach, one which was considered to align with person-

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[8] DNA- Did Not Attend.

centredness as well as conform to professional standards and behaviour. The next section turns to the second value of authenticity.

Authenticity

Espie et al. (2021) assert that engaging authentically with the patient is a feature of person-centred practice, where practitioners' knowledge of their own values and beliefs connects with their knowledge of the patient. This 'interconnectedness' is, they argue, a key aspect of person-centredness.

Authenticity, or giving a bit of themselves as people whilst still maintaining professional boundaries, was a key element in staff's construction of PCC:

> So, in anyone you're working with, working hard to find something to link you. So, like with the young patient we've got at the moment who is challenging in many ways, but one of the links I've got with him is a certain song that he likes is a song that's my partner's favourite song. So sometimes I'll come in and I'll just say: can we just play that song, and I think they get that authenticity from you which can be quite a challenge sometimes to find.
>
> (Sharon, workshop 1, brain injury rehabilitation)

Sharon links authenticity with being non-judgemental and not allowing personal values to impact negatively on the therapeutic relationship. This aligns with Espie et al.'s (2021) comment that "to engage meaningfully with another person means to accept them as they are" (p.122). The need to be personable is however constrained and regulated by professional guidelines regarding what is considered to be acceptable and appropriate professional behaviour (HCPC 2016).

Authenticity is also recognised by Kneebone in the development of what he terms 'voice' or how the practice is performed. The practitioner's 'voice' shapes the experience for the patient, and Kneebone (2020) asserts that "voice must be authentic. You are drawing on aspects of yourself that are already there" (p.210). Thus, personal and professional values are key to this development, which is ultimately aligned with professional confidence and identity.

The idea of adhering to professional values was also inherent in Joyce's comment, and she considers that person-centredness takes effort on the part of the clinician:

> I had someone years ago that I genuinely couldn't be in the same room as because generally values were so different and I really had to reflect on that

> and say, well, I have to. This is my job and I had to work extremely hard on my professionalism to be in there, see the person with what their values were. Where they're coming from. Reflect on that and go back in. It's hard. It is hard but once you've done it, it's finding that we all come with our own values, don't we, and our own…what do you call it? Not rubbish. Our own baggage and it's how that impacts on patient centredness and relationships.
>
> (Joyce, workshop 2, out-patients)

In the quote above not only do SLT values and the professional constraints therein inform how Joyce presents herself professionally, but the patient's own values influence and interact with SLTs' values. Staff considered that a patient's personhood could influence their own ability to create and maintain the therapeutic relationship:

> I think you really bounce off the person in front of you as to how you present yourself as well and it helps with the trust-therapist-patient relationship.
>
> (Carol, workshop 4, acute wards)

This is also noted by Nancy in the acute wards workshop when she states, "their own values would impact on how you are". My data suggests therefore that values actively shaped staff's understanding and construction of an ideal person-centred SLT, partly through their impact on building the therapeutic relationship. Hansen et al.'s (2024) review of therapeutic alliance in SLT highlights relational processes such as recognising the patients' personhood and being responsive as key to creating and maintaining the SLT-patient relationship.

Flexibility

The final value I discuss is flexibility. Staff perceived flexibility not only as an element related to service processes but also as a personal attribute or value, related to clinical confidence, which then affected how they practised. Being flexible allowed the SLT to discard set protocols and respond directly to the patient at the time. This aspect of flexibility in combination with active listening ensured that the SLT could start to build a relationship with the patient:

Joyce: I think confidence to go off piste I think... You've been doing your job and your role long enough to know when to sit back and listen and I think… if you're very new or maybe very young and with less life experience… maybe it's harder to

> do that without the support. So, it's just having that confidence to know that it's okay to sit down and listen.
>
> Charlotte: It's a good skill to have, to be able to go off piste and know when it's appropriate to do that. Quite often it's always appropriate to do that.
>
> Stella: Because I think it just shows humanity doesn't it…? If you are clerking in a patient and checking also how somebody else is feeling, rather than just going on your own agenda… So, it's responding to the patient.
>
> (Joyce, Charlotte and Stella, workshop 2, out-patients)

Here the out-patient team aligns person-centredness with recognition of the patient's feelings and emotions and the SLT's ability to change approach quickly i.e., to humanise the interaction. The flexibility of approach ("going off piste") mentioned by the out-patient team is akin to Kneebone's (2020) idea of "changing frames" or discarding "the approaches he'd been taught and the assumptions he'd grown used to" (p.155). Kneebone uses the phrase in the context of the development of mastery in a skill or profession, but it can equally be used in the context of adapting clinical approach according to the individual patient. Kayes and Papadimitriou (2023) also perceive being responsive to the patient and not being bound by pre-determined actions as one of the hallmarks of person-centred rehabilitation.

Having the flexibility to cross role boundaries was also perceived by staff as indicative of person-centredness and responding to the patient's needs:

> Having an understanding of when it's right to go outside of your role boundary really. You know, I don't know much about CBT[9] but I know what are good things and what can help people. It might not be specifically my role, but I can signpost… You need to be able to go that little bit further and then know, well, clearly, I'm well out of my jurisdiction here.
>
> (Joyce, workshop 2, out-patients)

Joyce here highlights how flexibility is constrained by the discourse of professional ethics, competencies and skills. There is a limit to the extent that the SLT can act in ways that sit outside of their professional role because SLT practices are regulated and superseded by professional discourses like the HCPC (2016) standards.

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[9] CBT – Cognitive Behavioural Therapy

Another aspect of flexibility related to SLT's willingness and ability to try new therapeutic approaches and not be constrained by traditional methods:

> I think, as well, they've all worked outside the box a little bit. No one has really just sat and done six direct therapy sessions, like they've all been a bit flexible in their approach.
>
> (Sabrina, workshop 1, brain injury rehabilitation)
>
> I think we've said the word flexibility quite a lot. We've all done speech therapy but in a completely different way and I suppose we've only got that flexibility, going back to what Siobhan brought, [a clock], through time, and time is spent to establish what they want out of you I suppose.
>
> (Helen, workshop 4, acute wards)
>
> I think being bold enough to change your perspective and implement things which are maybe outside of your comfort zone in terms of what you can provide.
>
> (Elaine, workshop 4, acute wards))

The acute team linked the ability to take a creative, bespoke approach to therapy to the professional flexibility of SLT, which in turn was aligned with being responsive to the patient's needs, underpinning person-centredness for them.

4.5 Chapter Summary

Through their use of metaphors, the SLTs constructed their practice as one that was based on a relational worldview, centring the patient within their own microsystems and relationships. The metaphors, images and the narratives used to explain them, convey SLTs as guides and facilitators who regarded the patients' physical needs as interwoven with their social relationships. These metaphors are not static but are explained contextually, in light of the need to support the patient as their needs fluctuate and change over time, but SLTs' aim is to facilitate the patient's personal and relational growth while nurturing their social connections with family, friends and community.

What has also emerged so far from the data is how trust, authenticity and flexibility were regarded as central to SLTs' person-centred practice and to how they constructed themselves as person-centred practitioners. Staff linked mutual trust, authenticity and flexibility to the processes of building rapport and creating the therapeutic relationship with the patient. In some instances, however, they believed that this ability to practice trust, authenticity and flexibility was constrained by professional standards and guidelines.

Figure 17 shows how SLTs' values, situated at the intrapersonal level of the SEM, interconnect with the individual patient, while the patient's own personhood also influences SLTs. This level of the SEM partly addresses RQ1, highlighting the values which underpin SLTs' practice and SLTs' understanding of the concept of PCC. In this chapter the SEM reminds us how PCC highlights the relations between SLTs' values and patients' personhood and context (see Figure 17); the chapter therefore also begins to address RQ3.

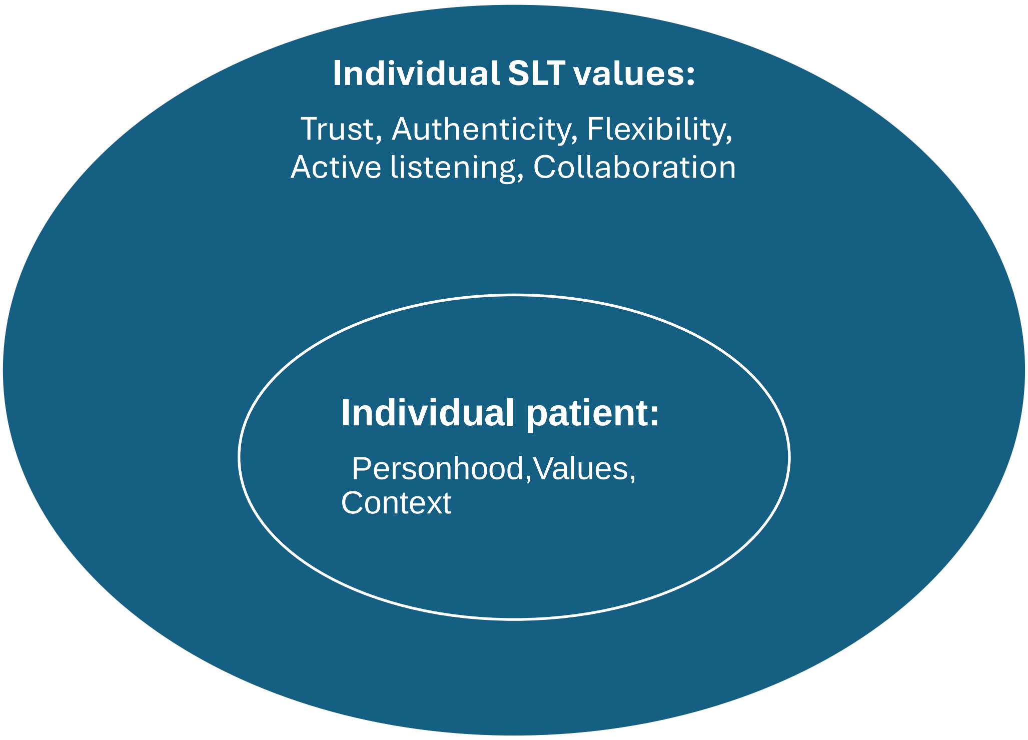

Figure 17: Intrapersonal level of SEM.

The SLTs present a professional narrative of person-centred care focused on the patient's clinical and socio-cultural context. The relations that come to matter in person-centred SLT intervention are those that radiate out from the patient: to family, friends and further into the patient’s community. These interpersonal micro-systems are targeted by SLT and included in their therapy plans as communication and swallowing difficulties impact upon a person’s social functioning and social practices. SLTs’ work on maintaining patients’ social roles is explored in detail in the next chapter.

Interpersonal level: Patient’s microsystems

Chapter 5: Patients’ social routines and relationships, a crucial role for SLTs within the interpersonal level of the SEM.

Overview

This chapter demonstrates how SLTs’ work facilitates the interpersonal and social level of the patient’s relationships that emerged as central to the concept of PCC in Chapter 4. The analysis here turns to the data generated in collated clinical vignettes or patient stories, and again the framing for my analysis is critical thinking around the socio-ecological model.

Two main types of vignettes emerged: communication vignettes and swallowing stories, around which the chapter is structured. SLTs’ professional aim is to re-engage patients in everyday life by enhancing communication and swallowing skills to maintain personal relationships, participation in wider social events or occupations and adherence to social routine. SLTs act as agents of change within these interpersonal microsystems. Relational recovery is achieved by work on the patient’s identity and sense of self, family or social routines and social practices. This chapter therefore emphasises the patient’s social roles, focusing on resumption of daily life.

However, as my analysis explores, the role of the SLT as described by the practitioners may be confined to these specific interpersonal levels of the socio-ecological system. I discuss the concepts (biographical reconstruction and materiality of care) arising from these stories and the implications for our understanding about SLT in PCC.

This chapter links to the first half of research question 1, and research question 3:

RQ1: What is SLTs’ role within PCC?

RQ3: How can a social-ecological framework contribute to our thinking on person-centredness within SLT clinical practice?

5.1 Person-centredness and everyday life

As started to emerge in Chapter 4, a central aspect of person-centredness for SLTs is their goal for patients "to resume their daily lives in the most productive and self-fulfilling way possible" (P45, online survey). For the participants, PCC includes responding to what matters to patients, whether it is maintaining personal relationships or participation in previous daily routines, which of themselves often comprise a relational element. This chapter elaborates on how elements of everyday life, such as routines, social practices and mundane everyday objects are intertwined in SLT clinical work on communication and swallowing.

5.1.1 Everyday routines

As I will demonstrate through my data, SLTs' focus on everyday life surfaces the importance of the mundane in the routines of social relations and practices (Neal and Murji (2015). Pink (2012) asserts that the everyday is so significant because it lies "at the centre of human existence, the essence of who we are and our location in the world" (p.143). These regular daily activities also help to give meaning and shape to our world, as Overholtzer and Robin (2015) note:

> Everyday life comprises the complexity of the experiences and interactions that we have with others and our material world. These day-to-day embodied routines are a nexus of activities and interactions that both give shape and meaning to our world and give us the ability to shape our world and make it meaningful.
>
> (Overholtzer and Robin 2015, p.3)

The online data contains examples of SLTs working on 'mundane activities' which allow reconnection with everyday life tasks, for example P13's comments:

> Going to the library rather than the shops because that's what they would normally want to do. Being able to communicate in the shops rather than [rely on] family members.
>
> (P13, online survey)

The data also shows how SLTs integrate communication therapy with tasks that are essential to negotiating the complexities of everyday life. For example, P77 recognises that for their particular patient, being able to access her finances independently or chat with friends is what's important to her:

> She has issues with managing numbers in patterns e.g., phone numbers and passwords, online shopping codes, post codes etc and chatting and explaining issues or stories.
>
> (P77, online survey)

Chatting or communicating meaningful small routines can be a significant part of daily life. One particular patient felt huge frustration that she could not convey her ‘small stories’ (Bamberg 2004; Bamberg and Georgakopoulou 2008) to her husband and daughter in everyday conversation. P77’s therapy provides a means of structuring conversation so that the patient can initiate the communication linked to everyday activities and events (small stories) which supports close relationships. SLT here is focused on reducing the impact of the communication disability on the patient’s daily life and in so doing, improving the patient’s wellbeing by sustaining meaningful small routines.

Daily routines may be most missed by people whilst they are patients in hospital. Meaningful consideration of the patient’s previous routine may be something very simple, as illustrated by Ava, who arranges for a patient to watch her favourite daily programme:

> The book [All About Me] also said that she loved watching Tipping Point, and that prompted me to liaise with healthcare support workers to bring her to the day room to watch it every day at 4pm.
>
> (Ava, electronic reflective diary)

Patients with severe communication difficulties may not be able to communicate their previous daily routines. In these cases, SLT staff engage with patients’ families or significant others to gain information about the patient. This information may then be used to compose a book (All About Me book) which includes information about the patient’s life history, significant others and personal likes and dislikes. This book also helps other HCPs to get to know the patient. Subsequently, the SLT facilitation of understanding routines for this patient means that the patient is also supported to attend a bingo group (another favourite past-time) and thus aspects of her pre-morbid daily routine is incorporated into therapy intervention.

The All About Me books emphasise the patient’s connectedness and life trajectory at an individual level while firmly placing them within a web of relationships. The books composed by SLTs recognise the inter-relatedness of patients within a “network of connections that span across time” (May 2019, p.90) and are situated within both the intrapersonal and interpersonal levels of the SEM. The individual information positively influences the interpersonal microsystems between the patient and other healthcare professionals.

5.1.2 Everyday objects

SLTs communicated through their narratives how their daily work involved working with patients’ everyday objects like glasses and hearing aids. During interaction with patients one of the SLT’s initial actions will be to ensure that sensory aids such as glasses or hearing aids are worn or switched on, to facilitate the patient’s comprehension as much as possible. SLTs‘ awareness of the importance of these everyday objects as sensory aids that support PCC is evident in Lily’s comment:

> I always clean glasses. I always look to see if their glasses are clean.
>
> (Lily, workshop 3, stroke rehab)

Elaine chooses glasses to represent person-centredness due to their personal significance for her. Mundane everyday objects can also form part of the person’s identity, as noted by Elaine. Elaine’s choice of object extends the appreciation of identity to include not only the feeling of safety but the protection from vulnerabilities which may be attached to certain personal possessions like glasses, which perform as “mundane technologies” or prostheses (Schriempf, 2009, p.289).

I am so used to wearing them that they feel part of my face and my identity. Without my glasses on I cannot see much at all, and it also affects my hearing as I cannot lip read or see facial expressions either.

A few years ago, I went to a great Dementia training day by a group called Relive and we were invited to think about what we would want someone to know about us if we were in hospital or a nursing home. I immediately wrote down that I need to have my glasses and that no one else is allowed to touch them! Without my glasses I feel so vulnerable, and I would want people to understand how important they are to my health and wellbeing.

Often our patients can have requests or needs which seem small but would make a huge difference to them. Taking the time to find out what they need, to understand and implement this is at the heart of patient-centred care.

Figure 18: Elaine's image, workshop 5, acute wards.

Creative use of mundane everyday objects such as handkerchiefs can also support a patient's identity both within the family and at the wider social level, while serving as tactile biographical anchors, for example to enable a patient to relate family and personal life stories at his own wedding. The anchors also provide a sense of protection against the vulnerability generated by the communication disability:

> With C and P's wedding coming up, C's lack of confidence in his ability to speak to friends at the wedding was causing a lot of self-doubt and anxiety. So, I felt that this should be the main focus for speech and language therapy intervention and through discussing with C and P we managed to create a highly creative tool for communication prompts to enable C to participate in a loving way with

> his friends and families and with his new wife within the wedding…little chats and funny stories or vignettes for friends. They were mounted on cloth which he then had, sort of, within handkerchiefs in his breast pocket, close to his heart and, sort of, being placed where he knew that he had them. So, he could pull them out and he used them as prompts to talk to family and friends at the wedding.
>
> *(*Rachel, workshop 1, brain injury rehabilitation)

Elaine and Rachel's stories draw attention to how mundane objects may have other, protective roles besides their ordinary everyday function. The objects here are also assisting communication by enabling the patient to recount their 'big' and 'small' stories (Bamberg 2004; Bamberg and Georgakopoulu 2008) to their personal micro-system of family and friends; at the same time SLT is enabling them to perform a specific social role which is expected of them with confidence. This powerful vignette again demonstrates that SLTs work at both individual and interpersonal, social levels but also highlights how manipulation of material objects by the SLT facilitates PCC.

Community staff regularly utilise patients' personal objects in the home to encourage conversation, which allows informal assessment and promotes motivation. Woodward (2019) notes that "objects are embedded in relationships to others" (p.74) and may convey or represent a particular relationship to their owners, for example, a gift from a family member or friend. The use of personal possessions as part of informal assessment therefore allows expression of personhood and identity by the patient specifically within their close personal micro-system.

Family photographs or albums are a key element of SLTs' therapy toolbox during home visits and form part of a regular 'script' adopted by community SLTs:

> 70% of the people that we go and see, whether that's in a nursing home, or own home, have pictures of their family somewhere. There is a picture of their family at some point in their house somewhere and not only does it represent their people, their tribe, their community but also, it's one of the easiest, quickest and most pleasant way of eliciting conversation.
>
> So, I often find that it's the thing that I will always gravitate towards when I'm trying to build rapport… you often find that people will light up more when they look at pictures of family… they're more likely to be animated about people that they know and things that they know.
>
> (Mark, workshop 5, community)

Mark's narrative places the patient within their own specific interpersonal microsystems and demonstrates understanding of the importance of social links and networks and how these can be utilised in therapy.

A patient story by P64 highlights the use of patients' personal objects as communication aids in SLTs' clinical work. In the following example, the patient is receiving palliative care, and communication ability is deteriorating quickly, such that the patient is becoming frustrated as he can't ask for things he needs:

> Arranged for my assistant to repeat a visit with a camera, to take photos of key objects around his house to create a communication book of the design he would prefer.
>
> (P64, online survey)

In this instance the SLT is using photographs of the patient's familiar objects as a functional tool to support patient agency and expression of identity through picture-person interaction (Lovatt 2018).

Higher level technology (i.e., electronic based aids) to support, augment or replace speech (alternative or augmentative communication – (AAC)) is also used by SLTs. P47 describes how they are focusing on triggering access to speech via use of mobile technology. The patient is an elderly man with chronic aphasia whose wife describes him as having no spontaneous speech. The SLT ascertains that 'he wanted to speak more and have better interaction with his granddaughter' in particular. As word repetition remained a relative strength, this is utilised to trigger speech:

> We identified core vocabulary to use in massed repetition and to input on to a communication aid to use as a trigger for speech. The type of communication aid was also patient centred, with different devices (iPad, smart phone) being discussed and trialled, as well as trialling different software. The patient took ownership of the selected communication aid, with me enabling him to choose his preferred voice, pictures and vocabulary to input and use.
>
> (P47, online survey)

The patient's wish in this story is recovery and positive development of one particular family relationship, thus relational recovery is again foregrounded. The pictures in the former story and electronic aids in the latter patient story *are / become* the patient's proxy communication as expressive language and speech either decline or are not enough to support relational identity (identity fashioned through social interaction –

see Dionne and Ells 2022). For this patient AAC performs a vital social and cultural role.

In addition to patients' personal possessions, SLTs in the community also make note of household objects within patients' home environment and utilise these when making their recommendations**:**

> Things like seeing the set up and if you have a look in someone's fridge, for example. You know, shall we see what you've got in here to see what we can do. It could be full of really good food or nothing. You start asking who gets your food." Oh, I'll be fine" and you think: prompt referrals left, right and centre to other places then.
>
> (Eva, workshop 5, community)

> What have you got in your kitchen? Oh, you've got a slow cooker. Great, you can slow cook the meat or show me your set up.
>
> (Odette, workshop 5, community)

These two examples show how domestic material culture or utilising household objects that normally "fade into the background of everyday practice" (Bird and Jensen 2022, p.2) allows the SLT to gain knowledge about a person's eating or cooking practices. This knowledge then shapes SLT recommendations and actions; for example, the contents of the fridge in Eva's story, in addition to other professional observations, help the SLT to decide whether the patient will manage their own nutritional needs, especially if this involves modification of food or fluid textures if recommended by SLT. The contents may also provide a window into the patient's social world e.g., a lack of home-cooked food may indicate isolation and a poor support network. The fridge in this example acts as a tool for the SLT and may set off a chain of actions regarding patient safety, activating SLT's relational role across separate professional agencies and teams.

5.1.2.1 Food as an object

Throughout this section I have focused mainly on tangible objects to explore how SLTs manipulate material elements to support person-centred care. However, SLTs' work on swallowing introduces the additional materiality of food (and drink), where facilitating the ability to eat or drink orally not only reinforces the relational element of eating and drinking but also supports the maintenance of everyday routines associated with mealtimes. Food plays an important role in everyday life, and as noted by

MacDonald et al. (2018) “food is intimately connected to social processes and social relationships” (p.780).

Eating (and drinking) constitute not only practices within the family but also wider social practices within the patient’s community microsystem. SLTs’ work on swallowing allows patients to participate in family practices related to eating and this not only benefits patients’ identity but also their spouse /partner or person who prepares and provides the food. For example, Odette discusses a patient whom she is working with in the community. The SLT is aware that the patient’s background and culture is Iranian; the language of the family is Farsi, and their cuisine is based on Iranian food. The patient is discharged home on a puréed diet and his wife is struggling to maintain the patient’s enjoyment of food:

> Food was an important part of his life, alongside his culture as well. So, I asked them what did they…like his favourite dish and it was a dish called Fesenjan which is like a Persian chicken and walnut stew. So, I made it at home, and I tried to modify it down to a level five[10] and wrote the recipe up and had it translated for them into Farsi so that the wife could understand how to modify those types of food and those types of meals in line with the recommendations.
>
> (Odette, workshop 5, community)

Here Odette is supporting and reinforcing food-as-caring, particularly the wife’s expression of care for her husband through preparation of a family meal. The patient is now able to eat the same food as the rest of his family albeit in puréed form. The SLT is minimising erosion of shared food practices within the family microsystem and ensuring continuation of the relational role of food and eating in addition to supporting the wife’s nurturing role. The SLT is not only treating the biological impact of swallowing difficulties but also supporting the cultural practice of food within a specific interpersonal microsystem.

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[10] Level 5 diet: this refers to level 5 (minced and moist) of the International Dysphagia Diet Standardisation Initiative (IDDSI) which is a framework adopted in all health and social care settings to describe the continuum of 8 levels for texture modified foods and thickened liquids for people with dysphagia (swallowing difficulties).

This aspect of working with the family to support food-related caring also comes to the fore in Katy's story. She is involved with a patient who is unable to eat, and all nutrition and hydration is via a PEG[11], which the family is finding very difficult:

> He was nil by mouth with PEG feed and his wife was really struggling to come to terms with, I think, it sounds like that grieving process of what her husband was like before and what he's like now and what they've lost… I think the family, they were really keen for him to eat… we're not always there just to see the patient. It's who else is involved and providing that support for family. It's not just that person.
>
> (Katy, workshop 5, community)

By use of Talking Mats, the SLT uncovers that the patient really enjoys beer, and 'it was very important to him'. Katy therefore creates a plan for the patient to have 'taste for pleasure[12] of level 4 beer' which ensures continuity of identity for the patient as a beer-drinking person (albeit non-alcoholic beer). The patient's family is also involved in the decision which appeases some of the loss experienced by them as they are able to support the preparation and modification of the beer for the patient. SLT is working with the family microsystem as the patient's dysphagia (swallowing difficulty) is impacting on family roles in addition to the patient themselves.

The relationality of food becomes even more important at the end of life, when food-as-caring adopts an even more poignant meaning. P21 recounts a story about a woman who is at the end of life, but due to miscommunication between the family members and the ward the family is under the impression that their mother is unable to eat and drink and therefore they have not given her anything for five days. When she is eventually seen by the SLT, the patient is not well enough for a swallowing assessment and therefore the SLT role becomes one of educating the family on mouthcare and 'comfort feeding':

> I decided that comfort feeding was most suitable as opposed to an assessment as this was not in the interest of the patient and ensured best quality of life possible. I liaised with a SN [staff nurse] who informed me that the family refused to give food and drink but on discussion with the family they were under

---

[11] PEG: Percutaneous Endoscopic Gastrostomy. A gastrostomy tube is inserted into the stomach and all nutrition and hydration may be given via this route rather than eating and drinking orally. This is common when patients have severe swallowing difficulties.

[12] Taste for pleasure: SLTs may advise the patient to have very small amounts of food or fluid, just for pleasure and not to meet nutritional needs. This decision is always made with the patient, family and often wider healthcare team.

> the impression that their mother was not allowed and were clearly distraught about this.
>
> (P21, online survey)

Ellis's (2018) empirical work into family food practices at the end of life stresses the importance of the everyday when a family member is dying. Food becomes one of the key factors in shaping relationships before death, and the SLT in this instance is aiding the patient's family to show caring through feeding. The emotiveness involved in feeding and caring is foregrounded in P21's story and the mouth as a site of care by the family becomes the conduit or site of relational communication between patient and family microsystem. SLTs' work on swallowing and oral health through the intimate or interpersonal space of the mouth also connects to direct body work by the SLT which also creates trust between the SLT and patient- / - family.

Food as a material culture assumes greater significance at the end of life where food-as-caring becomes one of the main ways for families to maintain a caring role, facilitated by SLT advice. SLTs' work with food integrates the biological and socio-cultural elements of the patient's life and again shows how work at the individual level of the SEM (with the patient) influences other microsystems (family) at the interpersonal level. Food can be considered to act as a lever in that it promotes and sustains family practices such as mealtimes but also provides a positive caring experience or role for families at the end of life.

Food is recognised in the sociology literature as a singular material culture as it is ingested into the body and therefore the materiality of food and bodies becomes entangled (Ellis, 2018). Bennett (2010) when discussing the materiality of food, recognizes this as a form of "becoming", where the materiality of food is altered by the acts of preparation and cooking. Food acts as an 'actant', forming an assemblage with the body.

> Food, as a self-altering, dissipative materiality, is also a player. It enters into what we become.
>
> (Bennett, 2010, p.51)

The concept of 'tinkering' (van Hout et al. 2015) also applies to SLT work as in effect SLTs are adapting materiality of food through demonstration and guidance e.g., how to change the texture of food by preparing it differently. According to Roe (2006), changes in the 'material signifiers' of food (texture, appearance and smell) may alter food's edibility. Roe's research was concerned with biotechnology but is applicable also to the changes to food which may occur in the embodied experience of dysphagia. In one respect, tinkering enhances the person-centredness of SLT input by making the recommendations unique to the individual. On the other hand, tinkering may reduce the individual's appetite for food due to its changed aesthetic qualities and impact on the family or carer's ability to use food as caring. Tinkering therefore occurs at the individual, intrapersonal level of the SEM, as well as influencing the patient-family interpersonal microsystem.

Manipulation and management of objects within SLT practice allows the SLTs to elicit information about the patient's life history and their significant others. This information "puts the individual in the context of their past, their webs of relationships, their possessions and their sense of location" (Smart 2007, p.45). Hence the conception of family and community microsystems is reinforced. SLTs' work with material objects and food links to relationality and identity, everyday routines and biographical reconstruction (see sections 5.2 and 5.3), as "objects, perceived, and seen, are inescapably part of everyday life and interwoven with its social practices" (Cleeve et al. 2018, p.735, drawing on Shove et al. 2012).

5.1.3 Everyday social practices – swallowing stories

Practices are considered by MacDonald et al. (2018) to be "part of the taken for granted or mundane aspects of everyday life" (p.781). Maller (2015), using a social practice ontology, defines the three elements of practices as meanings (meanings about how and why to do things), materials (e.g. objects) and skills. It is only when all three elements occur together repeatedly over time that a practice is realised. Practices therefore form a part of everyday routines.

The SLTs' swallowing stories highlight how their work targets interactions and social routines within the patient's micro-system of family and friends. Enya is working with a patient who wishes to eat Christmas dinner with her family. While Enya has advised the patient to reduce distractions and concentrate on her swallow, she also recognises that the patient's household is a busy environment. Enya and her colleagues are keen for the patient to "build those social interactions and that special family time" and incorporate their recognition of the patient's social context into their final recommendations. Their solution is to schedule the interactions after she has finished her meals: “perhaps at an end of a meal or when she’s finished eating or watching television together”*.* The social context here determines the SLT’s actions and shows how the SLT prioritises family routines and practices as much as possible within her intervention.

In the same way, Laura aligns the ability to maintain everyday activities like shopping or meeting friends for a coffee with a person-centred approach:

> What actually was really meaningful to him… it turns out it was going to the shop, but it was also lots of other things, just being able to go and have meaningful interactions. You know, communication interactions with people, like he mentioned one of the things like going to the Knap[13] and going to have a nice coffee down there.
>
> (Laura, workshop 3, stroke rehab*).*

Laura is ensuring that the patient can participate in their previous social practices (Morgan 2019) thus helping to re-embed the patient within their community and maintain key social ties. Through their work on swallowing in everyday environments, SLTs create a path back to previous social roles to support and maintain valued friendships and relationships. This also serves to reduce the biographical disruption (Bury 1982; see section 5.3) by adherence to social routines and social or relational identity (Dionne and Ells 2022), namely a person who is able to eat and drink orally (normally) with family and friends.

The emphasis on social roles is underpinned by Eva’s example of her work with a male patient who has Huntington’s Disease. After assessing his swallow, she is recommending a softer diet to reduce the risk of food entering the lungs instead of the stomach, with possible consequence of pneumonia or even choking. This is resisted by the patient who is not following recommendations because it has a negative impact on activities he enjoys:

> So, on a Monday, Wednesday and Friday he would go to town with his support worker and go to the Hayes Island Snack Bar and have a bacon butty and that was always the sticking point because I’d recommended, I think like a level five diet at this point, but it was really upsetting for him not to have his bacon butty on a Monday, Wednesday and Friday. So, it really made me think about actually

---

[13] The Knap is a local beach.

> what’s important to him? It’s not just about the safety of your swallow or the medical side but it’s about what it means to him.
>
> (Eva, workshop 5, community)

In this case, Eva has appreciated the emotional impact of changing his routine of having a regular ‘junk’ meal. By adopting a social approach to rehabilitation, Eva identified with the patient the appropriate foods available on the menu at his regular café suitable for his level of swallow. The successful change to a burger accommodates the social nature of the activity and the place of the cafe into her therapy. She is balancing the need to manage risk with the need or aim of accommodating the patient’s wishes. He is able to continue his role as a social being, and the enjoyment of this role is not lost:

> He could still go and have a chat with the same people and place his own order and everything but slowly make little changes to what he was having on those days. To modify the diet to make it a little bit easier, a little bit safer but also keep that enjoyment.
>
> *(*Eva, workshop 5, community)

MacDonald et al. (2018) comment that “food is imbued with emotions and caregiving” (p.790) while Delormier et al. (2009) state that food practices are “embedded in the flow of everyday life” (p.217). SLTs are targeting the relational aspects of food practices by ensuring that patients can continue to perform these practices within their normal everyday settings and with their usual social partners. Robinson et al.’s (2022) empirical study with families’ experiences of dysphagia post-stroke notes the importance of maintaining elements of previous routines such as eating together or even eating out on occasion and the data in my study further supports and aligns with this.

5.1.4 Everyday social practices – communication vignettes

As argued from the outset, a key part of SLTs’ role is that of communication, through the facilitation of speech or an alternative means of communication. Rachel’s story of her work with a patient with progressive aphasia is characteristic of the kinds of multiple ways in which communication features as part of PCC, and the elements that are needed for communication to be effective and meaningful. While communication is a key aspect of PCC, I use the concept of communicability to explain those elements that emerged in the data as relevant to SLTs, namely relational identity, relational recovery within personal relationships and social roles underpinned by communication skills.

Rachel's story demonstrates that the patient's relational identity as a compassionate and affectionate person is the ultimate focus of intervention:

> [Aphasia] was impacting upon his ability to take part in activities and relationships that were important to him. So, through discussion it became evident that P, what really mattered to him was…family and friends, and showing caring for them were part of who he was.
>
> (Rachel, workshop 1, brain injury rehabilitation)

Rachel also describes her work with another patient whose excessive swearing due to brain injury is disrupting his relationships with family. Under SLT guidance the patient devises a tool to help him and his family:

> I was able to observe him problem solving and coming up with ideas to manage some of his ongoing difficulties at home, such as having a swear jar in the house to help manage his awareness and his family's ability to manage his swearing at home. I felt I was able to guide him through this recovery.
>
> (Rachel, workshop 1, brain injury rehab)

Rachel's metaphor of a tree (Figure 8, Chapter 4) alerts us to the way that Rachel connects the SLT role to the value and ethic of recovery as growth. She mentions the rootedness as something that allows change over time and as a key factor in therapy. Rachel is focusing on the growth of this patient's relationship with his family by helping to erase unhelpful behaviours which act as negative influences, and she is supporting the reconfiguration of his new identity over time. Rachel's work with this individual not only has the direct effect of stabilising or improving family relationships but also indirectly reduces the risk of fragmentation of that family unit secondary to stress. Relational recovery is emphasized by SLTs throughout the data, particularly at the interpersonal level of the SEM; for example, P78's (online survey) comment aligns with this aim of helping the patient "to build or rebuild relationships with friends and family".

The necessity of working with the patient's family regarding effective communication within close personal relationships is underlined by Katrina's story concerning T, also a survivor of brain injury.

> His wife then telephoned the department and had a conversation, and she was really struggling with T at home and finding that he wasn't very engaged or motivated and not, sort of, wanting to be doing things, like he hadn't wanted to go to his granddaughter's birthday party and things.
>
> (Katrina, workshop 1, brain injury rehabilitation)

T's wife is offered counselling and education regarding the effects of the brain injury on T:

> They've been, sort of, on their own pathways and haven't really been brought together. So then because of Covid the sessions were done in the garden, but there were six therapy sessions with T and his wife and, sort of, involving her and her being more educated then about the brain injury and really understanding what was going on for T meant that for the both of them then the situation was improved.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Katrina's involvement ensures that the patient's relationship with their spouse and ultimately close family is nurtured and conditions that support relational recovery and re-growth are put into place. The patient's clinical outcomes in this case are closely interwoven with their social needs and align family activities with resilience and good mental health, for both patient and spouse. SLT here is an actor and the lever is people/relationships, working at both individual and interpersonal levels.

Another example of SLT's focus on communication within the family micro-system is provided by Ava, who is seeing a new patient with Parkinson's Disease (PD) in the out-patient clinic. The patient's speech difficulties and low volume, characteristic of PD, are causing frustration for his partner as she is unable to hear him. During the session they also reveal that their daughter's wedding is in six weeks' time:

> They told me that their daughter's wedding is in 6 weeks and are feeling nervous about the speech. We then identified this as the patient's short- term goal and agreed to put together a plan as to how he would achieve this in our first therapy session.
>
> (Ava, electronic reflective diary)

These examples highlight that SLTs work on patient confidence in communicative performances not only in their usual family roles but also roles associated with specific events such as family weddings where roles may be more socially defined. SLTs' work within the family micro-system ensures continuity of family roles and identity within and outside the family (Shadden 2005; Strong and Shadden 2020).

SLTs' approach incorporates identity work as an inherent element in building a positive identity for the patient, one which is linked to public communication for some or simply to capacity to communicate with others in a way that fosters positive relationships. Identity is also considered to be "the result of what people do and say in their daily practices" (Yuste et al. 2021, p.87) while Ellis (2013) asserts that "mundane, daily life is integral to understanding the ways in which families and relational identities are produced" (p.267). In this chapter so far, I have given examples of SLTs' focus on everyday communication routines: this focus then allows work on reconfiguring or maintaining patients' relational identities. Maller (2015) comments that daily routines impact on health and wellbeing; in particular, "health and wellbeing are considered outcomes of participation in a set of social practices" (p.54). These practices can be contained within the family or wider social practices within the community.

5.2 The emergence of biographical reconstruction in SLTs' conceptualisation and practice of PCC.

At this point in the chapter, there is an opportunity to reflect on the processes that are emerging in these accounts of re-building communication and identity. Theoretical concepts of communication and personhood are used to explore in depth how the clinical vignettes presented in this chapter reflect changes for the patient regarding their relationships, identity and everyday routines, all of which are considered to cause biographical disruption (Bury 1982; 1988).

Sudden onset of illness is described as a disruption or rupture in an individual's biography particularly if this change impacts permanently on previous physical abilities or social routines. Physical changes in bodily functions, which demand focused attention from the individual, are also included by Bury (1982).

The focus of SLT work is on reconstruction of patients' biographies by reframing identity (not necessarily a return to their pre-morbid identity) i.e., a process of *becoming* (Dionne and Ells 2022) and re-embedding patients into their previously enjoyed family and social routines. If this is not possible then SLTs facilitate and foster access to new social and occupational roles and routines.

Bury's (1982) concept is based on disruption within both personal and wider social relationships; alterations and adjustments to everyday life routines; and re-appraisal of future plans and life aspirations. Solvang et al. (2023) single out these processes when they define biographical reconstruction as “the work being done both by patients and by rehabilitation professionals in order to explore how post-injury life can be lived” (p.348) and this is echoed in the data.

As already discussed, one of the key elements of disruption following a serious healthcare event is a change to everyday routines. Engman (2019) bases their refinement of Bury’s (1982) concept on the role of embodiment in reformed routines, drawing on Merleau-Ponty’s (1962) phenomenological understanding of embodiment, and research in disability studies which explore how embodiment “shapes one’s experience of their own body” (Engman 2019, p.122). Merleau-Ponty’s (1962) perspective is that the body is “our anchorage in a world” (p.167) and Engman extends this to propose that the disruption experienced results primarily from the restructuring of everyday activities and withdrawal from established routines secondary to limitations to the physical body, and not from the illness experience itself. This withdrawal has relevance for the work of SLTs in communication and swallowing, as their work is aimed at patients re-engaging with previous social routines and activities, previously predicated on ‘whole’ bodies which allowed automatic and unconscious ability to eat, drink and communicate with others. Biographical reconstruction is linked closely with communicability in that SLT enables both a communicative and physical presence at a social level.

5.3 The emergence of *communicative* identity in the conceptualisation and practice of PCC

The communication work carried out by SLTs focuses on providing patients with a means of effective communication by any means possible, whether that be via speech, text, gestures, symbols or a combination of systems. This emphasis on communication rather than on speech alone reflects what SLTs call ‘total communication’ and what Schriempf (2009) terms ‘communicability’. It is identified as a core aspect of PCC by the SLTs, in part because it relates to their professional role as speech and language therapists (RCSLT 2022) and because it relates to the concept of what makes a person, in relation to other people around them, for SLTs working in a person-centred way.

Schriempf ‘s (2009) concept of communicability helps us understand how the concept of personhood seems to be embedded in communication as a therapeutic and social practice as described by the SLTs. Schriempf highlights how society values articulate spoken language (referred to as communication) as a means of legitimate normative subjectness. Schriempf contrasts this normalisation with deaf subjectness within hearing society to show how communicability, rather than communication, allows us to understand the role of the expression of 'voice' in human subjectness and sense of self. This is the concept referred to as personhood (see Chapter 2, section 2.5; Watson 2023).

To extend this argument Edelist (2016, drawing on Michalko 1999) extends the concept of communicability within the Deaf/sign language and Hearing/spoken language cultural binary by proposing that human subjectness in a normative hearing world is experienced as a form of 'estranged familiarity'. Edelist (2016) applies the phrase to deaf individuals "living within the hearing, speaking world" (p.305), which is both familiar and strange at the same time.

In the context of SLT and PCC, I propose that patients with communication difficulties experience a form of 'estranged familiarity' as they occupy a communicative '*in-between'* space. They occupy a particular place on the normative communication continuum between articulate spoken speech at one end and no speech at the other. In their case, the new unfamiliar world is that of communication difficulties while their previous familiar articulateness belongs to a world that is currently unavailable. They are, in effect, '*communicatively homeless'*. SLTs' work on communication aims to help patients negotiate this 'in-between' potentially destabilising space, where they are "shipwrecked from life" (Winn 2018, p.97) and develop a metaphorical, if not always literal, voice and thus communicability i.e., communicative presence, within familial and wider social and cultural domains. This work therefore links closely with work on patient identity, which seems to underpin the personhood being strived for by SLTs when they construct PCC.

Some aspects of the literature have encouraged us to think about identity as fixed. However, literature from SLT and the related field of rehabilitation reveal how changes in self-identity, are reported after brain injury (Ownsworth 2014; Thomas et al. 2015; Beadle et al. 2016; Harvey 2018) and aphasia post stroke (Yuste et al. 2021) as a reminder of the extent to which identity is not fixed. Ellis (2013) draws on research by Hockey (2010) who contests the assumption of a fixed or stable identity prior to illness events and instead notes the relational and temporal aspects of identity formation; that is, it is formed through relationships between people over time.

De la Mata et al. (2015; 2016) also posit that identity is constructed and re-assembled throughout the life course. This process is not solely reliant on health events or crises, rather it is predicated on ongoing, daily dialogical interactions with other individuals, within a range of social and cultural settings. Understanding the person as "always in-the-making" (Dionne and Ells 2022, p.378) is evident in feminist conceptions of person-centred care, underpinned by a relational ontology. In support of this dialogical framing of personhood, Dionne and Ells assert that "identities are contextual and relational" (p.383) and that the multitude of relationships and contexts that are encountered throughout life must be acknowledged and considered.

The analysis earlier has already acknowledged the role of micro-interactions as part of the therapeutic process of PCC in SLT. Here I draw from SLTs' online comments that acknowledge the multifaceted dimensions of identity that they encounter as professionals:

> My thoughts are that people are multi-faceted and complex, and they are usually not single islands in a sea of confusion, they are often connected in some way to someone else and those also have a relevance although not always in a way that is facilitating the needs, wishes and requirements of the individual.
>
> (P77, online survey)

Identity in this quote is recognized by the SLT as socially constructed, highlighting the multiple influences even at the interpersonal level. Identity is mediated by communication skills and the role of dialogue in identity is highlighted by Miller et al. (2011):

> Speech-mediated attribution of identity is ingrained in human discourse. Speech counts among the most powerful vehicles of identity and, through the constructed product of intersubjective interaction (Bucholtz and Hall 2005), forms who we are…Our speech window on the world announces how we wish to be perceived.
>
> (Miller et al. 2011, p.1066)

We return to the weighty idea that SLTs' work on communication skills and the wider field of communicability is therefore vital in reconstruction of identity and therefore alludes to the ideas of personhood/self that the SLTs are referring to when they were asked about PCC. Their conceptualisation of PCC as being underpinned by a focus on identity, and the ways in which SLT interventions are involved in reframing identity towards a more positive sense of self, is visible in the data:

kintsukuroi

(n.) (v. phr.) "to repair with gold"; the art of repairing pottery with gold or silver lacquer and understanding that the piece is more beautiful for having been broken

Kintsukuroi – “to repair with gold”; the art of repairing pottery with gold or silver lacquer and understanding that the piece is more beautiful for having been broken. Based on Japanese philosophy, this, for me, supports the notion of PCC and brain injury rehabilitation. As clinicians we have a role to empower and support people to reframe their identities.

Figure 19: Katrina’s image, workshop 1, brain injury rehabilitation.

The quote draws our attention to the ‘rebuilding’ of the patient, and SLT links the ‘broken’ parts with patient identity. Katrina aligns identity work with work on adjustment and achievements:

> In addition to reframing personal thoughts to allow for acceptance, the focus of today’s session was to reinforce a “new” identity by focussing on achievements and goals/activities which are values-based. I consider values-based goal setting to be strongly aligned with person centred care […] I consider that values-based goal setting gets to the “essence” of a person thereby driving truly personalised and enabling care.
>
> (Katrina, electronic reflective diary)

Katrina here is aiding the patient to recognise their strengths and assets to allow for a more positive mindset and possible modification of their previous values, linked to planning the ‘new’ future self. The ability to accept and adapt to changes post brain injury is linked to better rehabilitation outcomes (Thomas et al. 2015), while a focus on identifying retained abilities or competencies is associated with positive rehabilitation practice (Collicutt McGrath 2008).

5.4 Chapter summary

This chapter has presented the socio-ecological model of the patient residing within a network of microsystems, each microsystem composed of relationships with close family, friends or wider community connections. These relationships and associations are the focus of SLT intervention through their work on patients' communication and swallowing skills. The examples of patient stories provided demonstrate that SLTs' work is centred around the individual, with recognition of the importance of situating that person within their social and cultural space, whether that be their family, community, neighbourhood or even a geographical space.

SLTs are also focusing on creating a path to meaningful social roles that may be broader than immediate family, by targeting change and mitigating erosion within different elements of the patient's micro-systems. The patient, in effect, is in a state of 'becoming other' and SLTs use "social interaction and roles as the medium through which personal transformation takes place" (Reupert 2017, p.105).

The importance of relationships in the practice of PCC is highlighted by Waters and Buchanan (2017) who state that "relationships in person-centred approaches should take as much priority as care tasks" (p.1034). These relationships include not only supporting the patient to maintain existing relationships and develop new ones, but also the relationship between the HCP and the patient, which is felt to be key in the process of identifying life goals. SLTs' focus on the patient's personal and community connections aligns with Waters and Buchanan's (2017) findings that key person-centred concepts include: being supported to participate in the community, positive relationships and "being included in the day-to-day fabric of life" (p.1035), all of which are evident in my data.

This chapter also introduces the idea of 'estranged familiarity' and the patient as 'communicatively homeless' due to inability to occupy fully their previous familial or social communicative space. SLTs work on facilitating communicative presence or communicability via work on communication within familiar relationships, everyday activities and routines at individual and social levels. This in turn links to communicative identity and biographical reconstruction. Communicability allows the patient to negotiate not only everyday relationships and practices but other more socially defined communication practices, while the patient is in a state of ‘becoming’ or ‘always-in-the-making’.

Biographical reconstruction lies at the interface between patient lives and the process of therapy. The SEM shows that biographical repair occurs at different levels i.e. intrapersonal and interpersonal and highlights the different relationships that are important in repair. This evokes the kind of relationality mentioned in Chapter 2 as defined by Crossley (2011; 2015).

SLTs’ swallowing work, although focused on a different physical skill, is also an element of communicability as it allows the patient to re-enter their previous social world and re-kindle relationships associated with eating and drinking practices. Effective eating and drinking skills also provide opportunity for the patient to regain their physical social presence. Communicability therefore aligns with a biocultural approach to practice, covering individual and social levels of the socio-ecological system.

This chapter also discusses how SLTs use objects such as patients’ personal possessions, domestic appliances, and other materials such as food or drink, in their clinical work. Materiality of care is a concept evident in the sociology of health and illness literature (Buse et al. 2018; MacDonald et al. 2018) and involves making visible the process whereby physical objects, professional tools or even care processes (i.e., care pathways) are used in or even shape healthcare and SLT practice. This chapter has demonstrated how SLTs use materials such as everyday objects, food and patients’ personal possessions to provide intervention that truly recognises the person.

In this chapter materiality lies at the interpersonal level, with patients and families seeing SLT work at the everyday level; SLTs’ interaction and relationships with higher levels of the SEM is not visible. Materiality as part of the organisational level becomes more visible in Chapter 7 when the impact of Covid-19 is discussed.

This chapter highlights how the interpersonal level of the SEM addresses RQ1 by illustrating the roles that SLTs play in PCC; one role focuses on facilitating patients’ communication and thus relationships with family, friends and wider social roles within the community. Another SLT role pertains to improving patients’ ability to swallow, thus recovering positive relationships with food / drink and thereby social practices connected to these.

This chapter also contributes to answering RQ3, i.e., how the SEM influences thinking on PCC within SLT practice. SLTs' stories reveal they constitute the interpersonal level as rebuilding patients' social interactions with family and beyond, maintaining previous social routines and practices and reconfiguring relational identity. Familial, social and cultural domains are highlighted as foci for SLT work within this level of the SEM. Analysis using the SEM integrates and surfaces all the different elements within healthcare that influence SLTs' practice of PCC.

Figure 20 presents a summary of the themes arising from SLTs' work within the patients' interpersonal microsystems. The inter-connection between these microsystems and patients' and SLTs' individual levels are also displayed.

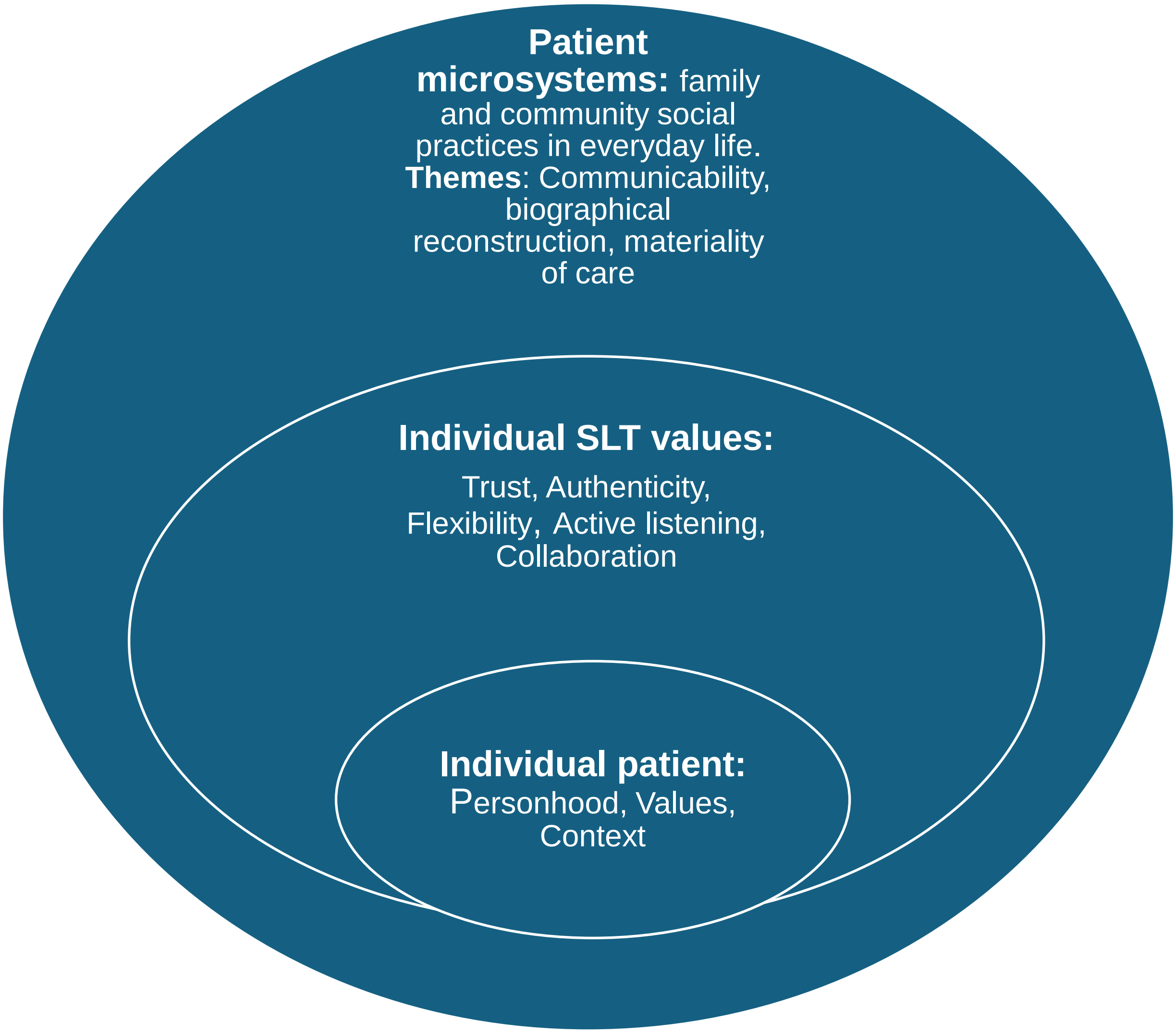

Figure 20: intrapersonal and interpersonal levels of the SEM.

Interpersonal level – SLTs' professional microsystems

Chapter 6: What helps or hinders SLTs' person-centred practice: positives and shadows.

Overview

This chapter reflects on staff's talk about their relationships with other HCPs and health systems, which became evident through the AI processes used in the workshop context. This chapter focuses on the relations between SLTs and their professional colleagues, which in turn shape the person-centredness of SLT practice. In accordance with the ethos of AI, positive elements of practice were the focus of discussion, but negative factors (shadow elements) also became visible which are useful to consider.

I use the socio-cultural perspective of Figured Worlds (see Butcher 2017) to make visible the multiple professional figured worlds (or clinical teams) that the SLT belongs to, each with its own values and practices, which influence enactment of person-centredness by SLTs. In particular, the biomedical discourse which dominates the hospital setting is used to exemplify issues of organisational power and hierarchy that constrain SLT practice and influence SLTs' professional identity. These socio-cultural elements are situated within SLTs' professional microsystems at the interpersonal and organisational levels of the SEM, and for ease of presentation these two levels are combined in this chapter.

This chapter links to research questions 2 and 4:

RQ2: What are the processes and relationships that facilitate or hinder person-centredness within SLT clinical practice?

RQ4: How can Appreciative Inquiry be used to explore SLTs' conceptualisations and practice of person-centredness?

6.1 Figured Worlds

Figured Worlds is a socio-cultural theory concerned with development of identity particularly in professional contexts. Developed by Holland et al. (1998) it draws on Vygotsky's work on identity and Bahktin's discourse theory (see Bennett et al. 2017). The approach considers the multiple discourses that can exist in a professional workplace and how these shape professional identities of staff, particularly students who are still developing their professional identities.

Figured worlds has been defined by Butcher (2017) as "frameworks of cultural, social and historical forces, constructed of common practices, interactions and local discourses" (p.42). In a healthcare context, each clinical team is its own figured world, with its own culture, values, and discourses. These are shaped and influenced by organisational culture which dictates service processes. Shared daily practices (for example ward rounds and team meetings) and activities between members of a figured world shape the meaning-making within each team and the expression of professional identity of each occupational group (Bennett et al. 2017).

Participants within these worlds are constantly 'figuring' i.e., adjusting their self-identity in relation to other actors within that setting, with power and hierarchy as influential factors. In addition, significance may be assigned to certain actions and particular outcomes being valued over others, for example attainment of key performance indicators such as rapid discharge. Thus, each social-professional context constitutes a particular figured world, with different impacts on SLT professional practice and identity:

> Identity formation is not just individually mediated but is also constructed between individuals and social context.
>
> (O'Leary and Cantillon 2020, p.792)

The idea of figuring out professional identity as a person-centred SLT is helpful in explaining how interpersonal, organisational and institutional issues of power and hierarchy impact upon SLTs' beliefs about their ability to deliver PCC. The clinical stories provided by the SLT staff reveal the various figured worlds to which they belonged, and the discourses prevailing in those contexts.

I consider initially the positive elements of practice highlighted by the SLTs and then expand the discussion into the shadow aspects although both aspects often co-existed. I also incorporate the teams' suggestions for further action into the discussion; some processes and practices identified were already highlighted by staff during the initial stages of the AI process, as developing elements that were working well would potentially lead to more person-centred outcomes. Many of the solutions identified by staff related to relationships and processes within the multi-disciplinary teams with whom SLTs interacted professionally. MDT working, sensitive outcomes that could be shared as success stories and highlighting person-centred practice when writing bids for funding all came to the fore. These are all inextricably linked, inter-related and reflect how healthcare practices are interwoven within a complex professional system.

6.2 Appreciating the positive

The method of AI allowed staff to identify positive themes (what's working well) via patient stories. Some of these have already become evident in the clinical vignettes and analysis so far e.g., SLTs' values of collaboration, respect and authenticity helping to build trust and form relationships with patients and their families, with patients at the core, and SLTs' focus on biocultural and social outcomes via communicability and swallowing work within the patient's personal and community microsystems. In Chapter 7 SLT peer support during Covid-19 also comes to the fore.

6.2.1. Positive: - SLTs' advocacy role

The method of AI facilitated positive narratives, one of which concerned advocacy work on behalf of the patient. In Chapter 5 communicability was highlighted as a way of supporting the patient's identity and subjectivity. SLTs' role as an advocate for patients with communication difficulties can be considered as a form of proxy communicability, working at the interpersonal level of the SEM. This advocacy gives the patient a 'voice'.

Advocacy is prominent in the talk of SLTs in both online survey and workshops. Charlotte demonstrates this through a story concerning a patient where she (Charlotte) has undertaken a significant advocacy role on the patient's behalf. The patient's communication difficulties in the workplace have resulted in a form of workplace bullying, where she is asked to clean rather than undertake any other duties connected to working in a shop:

> It's about supporting her to get out of the toxic environment that she's in, rather than changing how she presents…You're thinking of it as what's going to make life better for her… She needs somebody to voice her part because she just can't.
>
> (Charlotte, workshop 2, out-patients)

Advocacy in this case activated SLTs' relational role to the full, with Charlotte linking with the GP and multiple external agencies to ensure the patient's needs were fully met. It also demonstrates that advocacy can entail working across unclear role boundaries and illustrates again the underlying discourse of flexibility (Chapter 4), which staff aligned with person-centredness. The aim of 'making life better for her' taps into SLT's biocultural approach to practice, with SLT here acting as an agent of change targeting both occupational and daily life. This demonstrates the broad social outcomes that SLTs pursue for their patients.

6.2.2 Positive: - SLT outcomes

Workshop participants felt that SLT achieved successful outcomes for their patients but that social outcomes linked to SLTs' inherent biocultural approach are less visible than physical outcomes and often more difficult to observe. These outcomes can differ markedly from biomedical goals and take much longer to achieve than the health system currently allows. The participants felt that sharing SLT success stories with MDT colleagues through patient experience projects was, potentially, a means of making SLT outcomes more visible, while simultaneously educating the MDT:

> Involving people who have gone through, who have been patients, in service improvement and development… We've got a really untapped resource available.
>
> (Katrina, workshop 1, brain injury rehabilitation)

> Sharing the success stories and education through actual relevant patients or being able to go back to a ward where the patient initially came from and say, look at this success story.
>
> (Sabrina, workshop 1, brain injury rehabilitation)

Showcasing SLT outcomes, and the skills involved in obtaining those outcomes, was felt to be inherent to creating an understanding of SLT work in their professional colleagues. Staff linked the difficulty in demonstrating broad social outcomes with the lack of available outcome measures to provide robust qualitative data regarding SLT intervention and patient outcomes:

> But it's also the right sort of data and this is the thing, I think our profession suffers with, you know, people compare us to like a physio, is that often it's very obvious the physio work and they can spend twenty minutes with a patient and it's like, oh, brilliant. Whereas what we're doing is a lot more subtle and it takes a lot longer to achieve.
>
> (Elaine, workshop 4, acute wards)

The lack of clear qualitative outcomes from SLT intervention undermined SLTs' practice of PCC while simultaneously favouring other allied health professions who have more visible outcome measures, for example, physiotherapy, as suggested by staff in the quote above. The need for sensitive outcome measures was a recurrent theme across the different SLT teams:

> We also talked about outcome measures but delivering an outcome measure that is sensitive enough to pick up on the changes that have been made, rather than those standardised tick box type things.
>
> (Sharon, workshop 1, brain injury rehabilitation)

> We collect outcome measures but actually how person centred are our outcome measures, and do we collect any data about how person centred our care is and about how you would capture that anyway.
>
> (Helen, workshop 4, acute wards)

Increasing the visibility of successful SLT outcomes was felt to not only promote SLT within their teams but also to help align understanding of PCC across wider clinical teams. This is discussed further in the next sections of this chapter.

6.2.3 Positive: - Person-centred tools

In Chapter 4, I discussed how staff felt that their use of Talking Mats supported PCC. Likewise, the brain injury team considered that their use of other clinical approaches such as Acceptance-Commitment Therapy[14] (ACT), Solution Focused Brief Therapy[15]

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[14] Acceptance-Commitment Therapy (ACT): a type of mindful psychotherapy helping a person stay focused on the present moment and accept thoughts and feelings without judgement. It emphasises directing energy into healing instead of dwelling on the negative.

[15] Solution Focused Brief Therapy (SFBT): goal-focused therapy incorporating positive psychology principles; the focus is on solutions and not problems.

(SFBT) and Motivational Interviewing[16] (MI) enhanced their ability to be person-centred. SLTs' use of these 'tools' was felt to promote person-centred practice in a way that was different to the rest of the wider team:

> I think that speech and language therapists bring a certain slant to, like, if Sadie was to do an ACT group that might be very different to a physio doing an ACT group.
>
> (Katrina, workshop 1, brain injury rehabilitation)

SLT staff training in person-centred tools was felt by participants to be an essential step forward to ensure a person-centred approach. Although it was predominantly brain injury rehabilitation staff who used ACT and SFBT, it was felt these tools would be useful across the SLT service:

> But it could equally be used acutely. You know, in out-patients and in stroke. It could be everywhere, and I think speech and language therapists are now beginning to say, yeah, we can do this. We have the skills to be able to deliver it.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Increased use of these tools by SLTs was felt not only to develop the person-centredness of their intervention but also to be an opportunity to increase awareness of SLT skills by the MDT. Lack of awareness was construed as a barrier to broadening of SLT skills e.g., using tools which were historically the clinical territory of psychology:

> Having those things available and it not being frowned upon by other members of the team to be using them and to be skilled in doing it, I think that's an opportunity for change.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Katrina's comments regarding the need for justification of SLTs' scope of practice is reflected in Mak et al.'s (2022) publication which explores the professional identity of three allied health rehabilitation professions, including SLTs. This review, drawing on work of Ashby et al. (2013) and Loy et al. (2015) in occupational therapy, asserts that rehabilitation therapists often have to defend their scope of practice to colleagues who

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[16] Motivational Interviewing (MI): a collaborative, goal-oriented style of communication, designed to strengthen motivation and commitment to change within an atmosphere of acceptance and compassion.

have limited knowledge of what they can deliver professionally, which affects professional identity.

6.3 Shadow elements

Latter stages of the AI process highlighted different elements which influenced SLT's ability not only to practise in a person-centred way but also to present themselves to colleagues from other disciplines as effective person-centred practitioners. These elements comprised: lack of alignment of PCC across both the SLT service and wider MDTs i.e., HCPs' understanding of PCC; professional identity of SLTs within the organisation (also linked to lack of sensitive outcome measures to showcase SLT successes); professional hierarchies and relationships.

6.3.1 Shadow: – MDT understanding of PCC.

In Chapter 4, section 4.3, the SLTs' conceptualisation of PCC was felt by participants to be different to that of their colleagues. This was felt most acutely in the rehabilitation setting:

> How different everyone's view of person-centred care is across the disciplines, and how someone from another discipline might come along with something and think this is really person-centred care, and then someone else might think, oh, actually that doesn't tick my boxes for person centred care.
>
> (Anne, workshop 1, brain injury rehabilitation)

This contrast resulted not only in difficulties for SLTs in delivering what they considered to be PCC but also affected SLTs' professional identity, in that the team's model of working did not necessarily align with SLTs' preference. Development of person-centredness within multi-disciplinary teams was felt to be predicated on a shared definition and vision of PCC, with a team that was able to reflect and be willing to change:

> I think multidisciplinary team working would need to shift, I think, in terms of agreeing what person-centred care is and how we deliver it. It should be core to our rehab model.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Kayes and Papadimitriou (2023) acknowledge the difficulties in operationalising PCC in the rehabilitation setting due to "a range of competing definitions, concepts, and disciplinary-based frameworks" (p.2), which they deem unhelpful due to the complexity of rehabilitation intervention. The authors advocate for changes in organisational structures and processes which would support person-centred rehabilitation, in addition to the adoption of more relational ways of working i.e., personhood of both patient and HCP is crucial to the therapeutic intervention.

From the data so far, alignment of person-centred practice across SLT and the wider teams is an obvious theme. Brown and Mountain (2021) advocate creating what they term "communicative space" where HCPs can utilise a person-centred lens to reflect on how their values and beliefs influence their behaviour. In this way HCPs reveal their own personhood and connect authentically with other members of their teams. As Brown and Mountain (2021) assert:

> People who provide healthcare need to have an awareness of who they are and the ways in which they are connected with their world of practice, to become authentic persons who act in knowledge-informed person-centred ways.
>
> (Brown and Mountain 2021, p.286)

In the same way, supervision was suggested as one means of clarifying this approach not only within the SLT service but also wider within multidisciplinary teams:

> I think there's opportunities for change perhaps within supervision. You know, in how sessions are facilitated or how cases are discussed, and maybe within multidisciplinary teams as well.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Bennett et al. (2017) contend that within figured worlds theory, "space for dialogue and reflection" (p.256) is crucial for the self-authoring of developing professional identity. Similarly, Katrina suggests that dialogue within a supervisory space could facilitate re-authoring of a team's identity as person-centred and make visible how this could be achieved through possible changes in practice and processes. Working processes which developed more inter-disciplinary ways of working were deemed appropriate to developing person-centred approaches within wider teams:

> Working processes can promote IDT[17] working but IDT working also seems, to me, to be a stage in team development & working. IDT practice requires time to develop so that there is shared and agreed service/team vision, a shared definition of what PCC means to that team (irrespective of discipline), and

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[17] IDT: inter-disciplinary team.

> knowledge and trust in accepting a blending of role boundaries in how we work rather than a fixed allegiance to one's own profession/discipline.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Katrina's comments regarding inter-disciplinary teams align with Papadimitriou and Cott's (2015) research on client-centredness and inter-professional team working in rehabilitation contexts. The HCPs participating in their study perceived client-centredness was related to aspects of team functioning, particularly good communication, shared knowledge of roles and competences, and mutual respect underpinned by a shared philosophy of client-centredness. The authors highlight how practising client-centredness is predicated on relationships at different levels within healthcare, similar to the SEM:

> Interactions between individual practitioners and clients during rehabilitation do not exist in a vacuum. These interactions are nested within a complex network of social relationships – the individual practitioner within the team, the team within the organization, and the organization within the broader health care system.
>
> (Papadimitriou and Cott 2015, p.1136)

Processes and structures affecting organisational and team culture and hence person-centredness are thus emphasised, as well as individual values and behaviours. These socio-cultural relationships all came to the fore in the SLTs' discussions of their practice and stress the dependency and interaction between them.

6.3.2 Shadow: – MDT understanding of SLT role.

Data so far exemplifies how SLTs believed their professional identity was not robust within the wider healthcare teams. Each separate team acted as its own figured world and had its own professional discourse which was then at odds with SLTs' discourse and self-perception of SLT skills and knowledge. In addition to this, each profession had its own interpretation of what PCC is and how to provide it. This tension undermined SLT's ability to work according to their own understanding of PCC.

Staff felt that SLT presence in more MDTs would not only enable a timelier service, with a shared vision of PCC, but also ultimately lead to increased respect for the service and the profession through showcasing of successful outcomes. As a core member of the MDT/IDT, SLT outcomes would become more visible, and as Joyce (workshop 2, outpatients) commented, "perhaps being in the MDT more directly we can show practically our worth more”. One suggestion as to how to achieve this was involving other members of the MDT in SLT projects and /or to emphasise the skills required to deliver the clinical work:

> I think there’s an education maybe as to, like, when we’re presenting a project, for example, to really break down the skills and the reasoning and the rationale and everything behind that, and it’s not just that you’re getting to the crux of the person. It’s actually, there’s quite a lot that goes on in the planning and behind it.
>
> (Sharon, workshop 1, brain injury rehabilitation)

Within Sharon’s narrative is a discourse of SLT skills being undervalued, also present in Siobhan’s comments:

> I think we’d be really respected as a profession as well because if the doctors know what we’re doing and families know what we’re doing, like other allied health professionals can see what we’re doing and the outcome, I think we’d come across quite differently, not only as a service but as a profession.
>
> (Siobhan, workshop 4, acute wards)

Mak et al. (2022) note that lack of understanding of a profession (in their example Occupational Therapy) can lead to ambiguity of their role, and call for more research into how professional identity may be shaped by (lack of) awareness by colleagues. The wish for professional respect and acknowledgment from colleagues was aligned with SLT outcomes and values also becoming more visible to patients’ families:

> How to share it with the families as well. How to say that this is what we did do. These are the values. This is what it’s based upon. This is where it comes from.
>
> (Enya, workshop 3, stroke rehabilitation)

> We don’t cure them, but we do other stuff, don’t we, that is not what people think of speech and language. So, how we express what we did do as part of our role and it’s not about getting that perfect speech and language back because that doesn’t happen.
>
> (Lily, workshop 3, stroke rehabilitation)

Promotion of SLT successes across the organisation was another action which was suggested to increase visibility of SLT skills and change professional perceptions of SLTs’ role. Nadia’s (workshop 3, stroke rehabilitation) solution for this was the creation of a specific role promoting SLT across the organisation “It’s almost like we need a PR person in our team”.

The lack of knowledge regarding SLT skills and role also affected their relationships with other HCPs, exacerbated by organisational culture.

6.3.3 Shadow: – SLTs’ relationship with other HCPs

Issues of power and hierarchy which impacted on SLTs’ practice were evident in the data, as the biomedical culture dominated the hospital setting, in turn affecting SLT’s confidence and relationship with medical teams:

> Nancy: I think it’s confidence as well … and being involved with, not challenging, but questioning, say, like the medics’ plan. It’s really easy to become quite submissive to a medical team.
>
> Carol: Absolutely. It’s having that confidence to say, actually I don’t think that’s what that patient wants. Let’s revisit that with the patient. I got completely shut down by a doctor this morning for that exact thing.
>
> Elaine: It’s hard to come back from that then, isn’t it? Once that’s happened to you it’s hard to then go back on the wards and do it again.
>
> Carol: So yeah, that is a challenge. Again, it’s a culture, isn’t it? Very medical.
>
> (Nancy, Carol and Elaine, workshop 4, acute wards)

The excerpt above aligns with Bennett et al. (2017) who note “positioning…arises from day to day experiences of power” (p.252). SLTs’ professional identities are positioned as submissive to the medical teams and thus professional hierarchies affected SLTs’ ability to practise their form of person-centredness. In the quote above SLTs are using a discourse of confidence as an indication of their ability to be person-centred in that setting. Their narrative also indicates their belief that to be person-centred they had to constantly battle and contest their positioning.

The impact of these relationships was exacerbated by other barriers raised by organisational hierarchies and culture, often based on a biomedical agenda:

> Just the environment of the acute hospital, isn’t it? It’s all very, like, you’re just targeting the medical issue and getting them home.
>
> (Carol, workshop 4, acute wards)

Discourses linked to medical culture not only impacted on SLT staff's ability to practise relationally but also highlighted ongoing issues with SLT's professional identity across the organisation. There was a lack of understanding of SLTs' role, particularly when SLT was not embedded within the MDT. Nancy highlighted differences between acute wards and services where SLT was embedded into the team and those where they were not so well established: "they're not used to your role, or they've got an opinion on what your role is", while Carol offered an example from another acute ward: "that same doctor asked: 'why would we refer to you?'"

Even when SLTs were embedded into MDTs, lack of awareness of the breadth of SLTs' role in that setting persisted. For example, Sharon commented understanding of SLT skills was not always evident or appreciated within the wider rehabilitation team:

> I don't know about everyone else, but to explain in terms of, like, values-based goal setting and all that stuff is that it's not a tick box exercise. It's not a process used. It's not a case of, you know, anyone can go up and extract that from the patient because it's all those people often see them as soft skills, but it's all those skills that go along with it that helps you to tease them out. So, I often find that the team try and process and make things into a process that actually sometimes isn't a process.
>
> (Sharon, workshop 1, brain injury rehabilitation)

Values and typical practices of the team(s) that SLTs were involved with influenced enactment of person-centredness by challenging SLTs' approach. The confidence to pursue a person-centred perspective became more difficult for staff and these difficulties highlighted the link between team culture, processes and local daily practices.

6.3.4 Shadow:– local and organisational practices

Quantitative outcome measures adopted by clinical teams are an example of local daily practices which created tensions between person-centred practice and what the team/service considered to be an evidence-based approach. For example, the stroke team was constrained by the discourse and practice of SSNAP[18], which produces a

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[18] SSNAP- Sentinel Stroke National Audit Programme, which advocates that each patient who has had a stroke should receive a minimum of 45 minutes a day from each therapy discipline if required.

rating for each separate discipline based on the amount of therapy provided to stroke patients:

> We've got SSNAP constantly. You know, it's always in the back of our mind all the time and it's very target driven, process driven.
>
> (Carol, workshop 4, acute wards)

Carol illustrated through a patient story how the performative aspect of SSNAP resulted in tension for SLTs between team/organisational structures and processes and the SLT values underpinning a person-centred approach:

> So, it's, kind of, breaking down that culture of processes and really…focusing on the patient. So that was the difference, and obviously we weren't going to get a score SSNAP target with him because he just wanted, like, ten-minute chats every day. Not forty-five-minute therapy. In terms of person-centred care, it would have been really good, that's a really good story. In terms of … meeting targets for stroke, it would have been terrible.
>
> (Carol, workshop 4, acute wards)

Staff acknowledged the difficulties of delivering their version of PCC within the constraints of the healthcare system, which was felt by Joyce (workshop 2, out-patients) to be "a medical model and it's about targets and that's how the NHS is run". This perspective was reinforced by Katrina:

> There's a bit of a conflict really because although we might be very person-centred in our approach, the systems that we're within give a nod to person-centred care but actually they're strongly linked still to patient-centred medical resource management.
>
> (Katrina, workshop 1, brain injury rehabilitation)

Within SLT discourse there was evidence of feelings of powerlessness, and of having to 'fight' the system to achieve their preferred outcomes:

> Helen: To make this the best outcome for the patient I want to do this, but it's kind of stopped by whatever policy and procedure is out there, and I appreciate that you have to have policy and procedures and management of groups and patients and that's how you manage a hospital. You can't manage it any other way, but I suppose the degree of flexibility coming from the top down…
>
> Siobhan: You have to fight every policy to get there.
>
> (Helen and Siobhan, workshop 4, acute wards)

There was recognition by staff that a top-down approach was required to effect change in organisational culture and systems: “You almost need the person at the top of it to understand it and want to drive it through” (Katrina, workshop 1, brain injury rehabilitation). This is also recognised in the literature on embedding person-centredness within a rehabilitation setting (Kayes and Papadimitriou 2023) and in wider healthcare contexts (Edgar et al. 2020).

My data highlights the inter-relatedness of the different levels of the SEM and how each level interacts with and is predicated on the other levels, creating tensions and mismatches between systems and PCC; this is echoed in the literature:

> Research highlights a tension between organisational, system and professional factors and attending to the needs and preferences of persons.
>
> (Kayes and Papadimitriou 2023, p.7)

The need for changes at individual, interpersonal and organisational levels to promote person-centred cultures is noted by many authors, but Cardiff et al. (2018) observe that leadership in person-centredness is still at a nascent stage. Many leadership styles employed in healthcare were not developed for that workplace context but have been transferred from other settings and more transformational leadership is required (Edgar et al. 2020, drawing on Lynch et al. 2018).

6.4 Chapter Summary

The workshops uncovered narratives and practices at interpersonal and organisational levels. The examples showcased SLTs’ person-centred practice but also exposed factors which hindered SLTs’ attempts to practise in a person-centred way. Professional teams can be imagined as separate figured worlds, each with its own culture, values and practices, which did not always align with SLTs’ approach. Application of figured worlds theory allowed recognition of the kind of relationships that SLTs experience or anticipate. It responds to the SEM’s dynamic nature by bridging the gap between the imagined and the physical; it highlights the relationality underpinning SLTs’ clinical practice by surfacing professional relationships, hierarchies or policies which influenced SLTs ability and confidence to practise PCC i.e. those relationships which intersected the SEM both vertically and horizontally.

The data presented illustrates the interwoven nature of different elements of healthcare practices. SLTs' professional identity was entangled with their (in)ability to evidence successful outcomes for their patients: showcasing positive outcomes could promote SLTs' professional identity across the wider healthcare teams and the organisation. However, this identity was also predicated on and affected by professional hierarchies and biomedical culture.

The data reveals that at that point in time staff felt eager to pursue certain actions identified via the workshop activities, those being: showcasing SLT success stories with other teams within and external to the organisation; pursuing exploration of more qualitative outcome measures which highlighted biocultural, social outcomes; and involving their patients in service projects.

In contrast, staff felt disempowered by biomedical culture and professional hierarchies which dominated certain clinical settings and acknowledged this could often affect their confidence in practising in a relational manner. Overall, where SLTs were embedded in MDTs, team working was felt to be mostly multi-disciplinary (that is, working in professional silos) in nature and not inter-disciplinary, impacting not only on professional identity and recognition of SLT skills, but also preventing a shared vision of person-centredness within the wider team. Finally, staff training in specific person-centred tools such as ACT, SFBT and MI was advocated across the SLT service, with further embedding of relational practice within teams via supervisory processes. This data emerged out of the dialogue generated during the AI workshop and was not present in the initial two activities, hence the combination of methods allowed highlighting of more than one level of the SEM.

This chapter addresses RQ2 and RQ4. The AI methodology exposed the processes and relationships at interpersonal and organisational levels of the SEM which negatively affected SLTs' person-centred practice. At an interpersonal level professional hierarchies and lack of awareness of SLTs' role by other HCPs impacted on SLTs' ability to practise PCC; at an organisational level biomedical culture affected SLTs' confidence in pursuing person-centred outcomes for their patients. However, the positive patient stories shared by staff also illustrated SLTs' role in PCC and thus link to RQ1.

Figure 21 summarises the analysis so far:

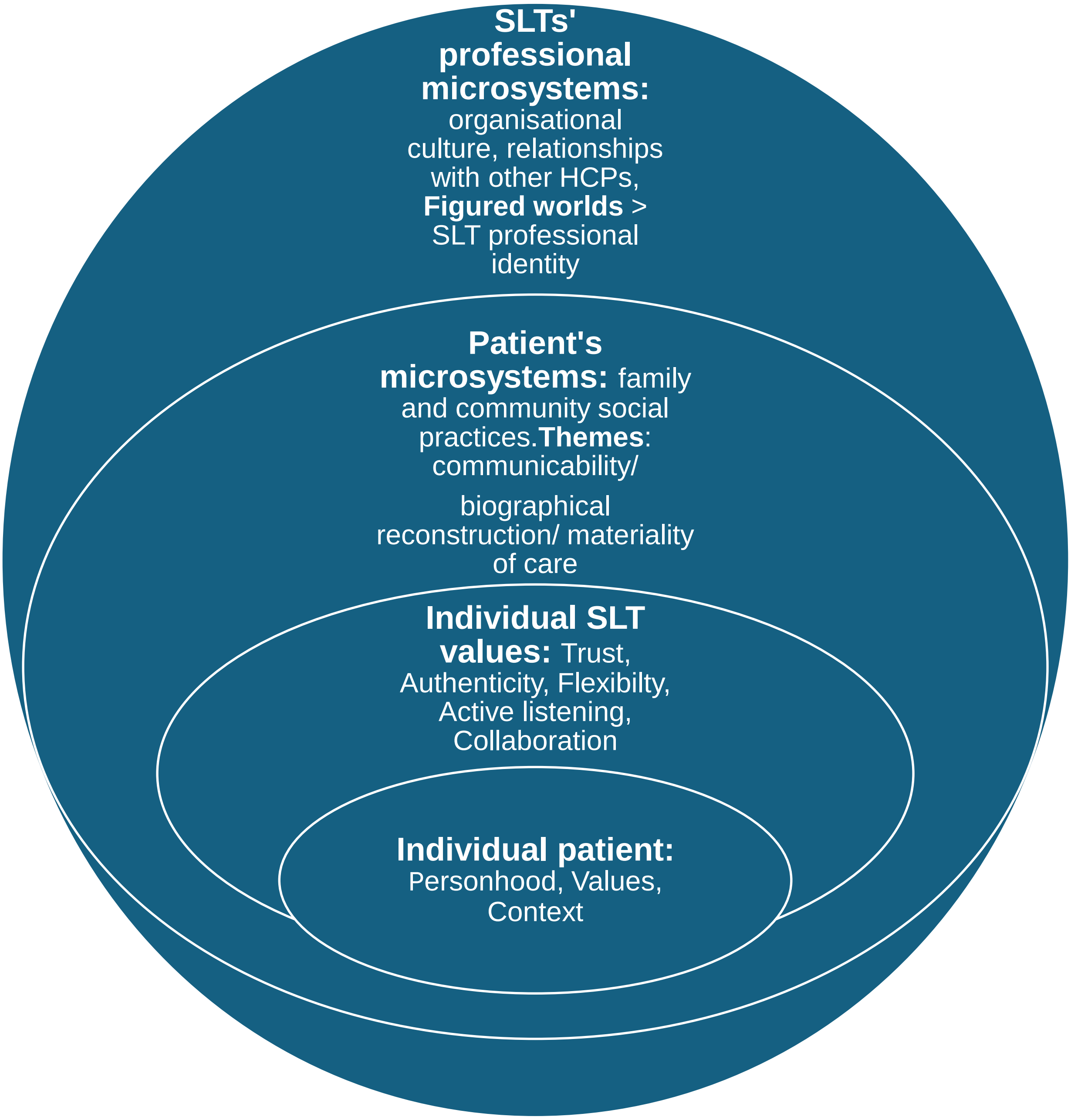

Figure 21: intrapersonal, interpersonal and organisational levels of the SEM as constructed by the SLTs.

Organisational level

Chapter 7: Impact of Covid-19 on PCC

Overview

This chapter continues the analysis using the SEM and systems thinking and is situated at the organisational level, even though there is considerable overlap between the interpersonal and organisational levels. This chapter extends SLTs' account of their conceptualisation of PCC and what matters to patients in PCC especially in the context of Covid-19, where the relations between individuals, communities, and organisations (ecological models) changed, along with effecting changes to SLTs' everyday work. SLTs argued that their usual collaborative, relational practice became limited to a more medical reductionist model overall due to the lack of contact with families and the need to discharge patients quickly from hospital.

The impact of Covid-19 on PCC on material practices of care is also highlighted, namely the reduction in time spent providing individualised care, and the ways in which the key values and practices of person-centredness were abandoned during a health care crisis. I have referred to the latter in terms of fragility, and tenuousness of PCC is emphasised through clinical stories and vignettes collected during Covid-19.

The final theme of SLT acting as a social bridge between patients and families is introduced whereby SLTs work to maintain links between patients in hospital and their families, a practice becoming particularly evident during Covid-19. As hospital visiting was not allowed, it became apparent that SLTs took on the emotional labour (Hochschild 1983; 2003) of facilitating patients' contact with their families. As the analysis will show, this emotional labour was extended also to peers and colleagues.

This chapter links to research question 2, with a particular emphasis on the impact of Covid-19:

RQ2: What are the processes and relationships that facilitate or hinder PCC within SLT clinical practice?

In this chapter I again draw on clinical vignettes and images to highlight and illustrate the effect of Covid-19 on both patients and SLT staff.

7.1 Impact of Covid-19

Data collected for this study (July 2021- February 2022) coincided with the second and third waves (in the UK) of the Covid-19 pandemic. This context influenced SLT practice as the pandemic highlighted, extended, and made visible the SLT role in communication:

> In ICU setting it has put more focus on our early intervention work/giving someone a voice with a tracheostomy[19] - this has been a priority to enable therapy MDT to communicate with patient to allow them to communicate their choices/goals/priorities.
>
> (P40, online survey)

As the data show, SLTs played a key role during Covid-19, not only due to their rehabilitative role (necessary for any ITU or long-term hospital patient) but also because of the ancillary roles that all healthcare workers took up during Covid-19 in staffing of all hospital care. In particular, during this time, as families were separated from each other and unable to visit relatives in hospital, SLTs played a key role in facilitating communication between patients and their significant others. This part of the SLTs' role and the importance of families became more prominent during Covid-19 because the rehabilitation needs of patients increased, resulting in long hospital admissions. Patients' need for social contact via virtual means or conversation with staff became even more important. In addition to patients' need for family contact, lack of contact with families also impacted on SLTs' ability to be collaborative in their practice, such that families were often not aware of the full extent of patients' needs on discharge from hospital.

The other main finding is the importance of staff wellbeing during the pandemic and how the support of colleagues helped staff to maintain resilience. Staff participating in workshops, especially later workshops during December 2021 when Covid-19 levels were again high, repeatedly reported feeling stressed, either redeployed or flexing from their usual roles to help nursing colleagues with basic care on the wards.

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[19] A tracheotomy is an opening created at the front of the neck so that a tracheostomy tube can be inserted to aid breathing. In the intensive care setting the tube is connected to an oxygen supply and a ventilator. This means that air is diverted from passing through the larynx (voice box) resulting in inability to produce voice. The SLT in ITU works with the person to produce voice via a specific speaking valve. During the pandemic all patients in ITU with severe Covid-19 had a tracheotomy.

7.1.1 Changes due to organisational drivers

SLTs' overall focus of care changed/reduced to the patient's biological need, which they explained as a shift away from a holistic person-centred approach encompassing all aspects, including physical as well as psychosocial care. This change of focus reflected SLTs' response to a need communicated from a higher, organisational level (see also the SEM), which allowed quicker transfer of patients through the hospital system so that beds could be vacated. The impact of responding to this organisational requirement was that communication therapy was delayed until the community setting and work on swallowing was prioritised to enable faster discharge. Online survey respondents noted that priority for quicker discharge resulted in patients' needs being disregarded ("little regard for what the patient wants"- P43) as person-centredness was forfeited for service-centred care ("input was based on what the service needed, not what patients personally needed/wanted" - P31).

> Covid also created more pressure to get patients out of hospital wherever possible which meant that person-centred care was forfeited for functionality so that patients could move on and receive other input.
>
> (P39, online)
>
> I feel the PCC agenda has taken a step back with a medical model of service delivery generally taking priority.
>
> (P46, online)

The impact of Covid-19 on SLTs' ability to perform their professional roles cannot be underestimated for staff, who instead became part of the large NHS workforce recruited into wards to provide basic care, some of which would have been provided by family members who now could not visit. Covid-19 changes impacted on the provision of PCC but also on the wider areas of patients' lives described in many ecological models. For patients returning home, the negative consequence of this quicker discharge process was highlighted by the stroke rehabilitation team who recounted many patients were sent home so rapidly that underlying swallowing difficulties were not realised by ward staff. This was due in part to ward staff not having had time to get to know the patients, or the time patients had spent on the ward was not long enough for all their difficulties to become obvious to staff:

> I think the emphasis being on getting people out, the difficulties sometimes aren't showing, particularly strokes are evolving. They don't show until they get home, and we were picking up, sort of, more complex, particularly around dysphagia, I think, or more dysphagia that hadn't necessarily or just hadn't had the chance because people had been on the ward for twenty-four hours in terms of monitoring.
>
> (Enya, workshop 3, stroke rehabilitation)

Also in workshop 3, Nadia comments that patients had 'not even eaten a full meal' in the short time that they had stayed on the acute ward or, as Lily observes, never had a slice of toast because they had porridge'. Patients' swallowing difficulties were masked by smoother and softer food textures and only apparent when patients struggled to cope with normal meals in their home environment. This was identified repeatedly by SLTs as an example of the reduction in person centredness overall created by the pandemic, which prevented even the most basic physical need of each patient being fully met. Undiagnosed swallowing issues resulted in increased risk to the patient after discharge e.g. risk of choking or developing chest infections/pneumonia from food or drink entering the lungs. A 2022 RCSLT report notes: "there were direct consequences relating to individuals' speech, language, communication or swallowing needs. Individuals were presenting to healthcare services later, which was often coupled with more advanced or severe needs" (p.7) and "the exacerbation or increased complexity of needs" (p.16).

Covid-19 also acted as a barrier to SLTs' usual therapeutic focus on relationships due to families' inability to visit hospital wards at certain times during the pandemic.

> This would normally be something that forms a key part of my practice, however in the wake of Covid it has been increasingly difficult to involve carers, family and others due to limited time to be on extended telephone calls. There have also been frequent difficulties with understanding of the individual's needs in the absence of seeing someone face-to-face.
>
> (P36, online survey)

Changes because of Covid-19 impacted the ability to be collaborative. Collaboration and communication with families were regarded by staff as vital to person-centredness, a theme explored in Chapter 4. During Covid-19 the SLTs reflected on the lack of partnership with families and staff's lack of ability to share the patient's rehabilitation journey with the patient's significant others, which they argued was a potential disruptor to relational recovery. This risk was brought to the fore during the stroke rehabilitation team's reflections on a patient story:

> Families aren't able to come in and they don't see the level of impairment. They don't see the journey. You know, they've dropped them off at A&E and for ages they weren't seeing them face-to-face until the point of discharge. So, they haven't seen, and they haven't been with them through that rehab journey. I remember, sort of a few discharges that we had, and we picked them up, families were just really, sort of, took a long time to accept that the changes were so significant because they couldn't process, even that information had been shared with them, they couldn't process it. They couldn't see it and see how it related into their lives.
>
> (Enya, workshop 3, stroke rehab)

It was argued that Covid-19 was responsible for disrupting the team's usual practice of including families in the rehabilitation process, resulting in 'incomplete' person-centred practice as the family's needs were not met. This disruption also extended to the goal setting process as limited connection with families resulted in misunderstandings between the team and patients' families regarding the appropriateness of therapy goals. Subsequently SLTs' effectiveness as levers for change within the patient's microsystems was reduced. This mismatch between family and team is demonstrated through a story about a patient in the community referred to SLT "to write a shopping list and do things like that":

> It became apparent that actually before the stroke he did everything for her anyway and there was no medical reason for that. So, I think it was week six and he told me then that actually she was depressed before the stroke which is why he did everything. So, I think as a team we had to reflect on the fact that the goals we were working on, she wasn't doing that before the stroke anyway.
>
> (Laura, workshop 3, stroke rehab)

Tara reflects that "sometimes we do infer goals" and Laura comments how social norms related to everyday practices ("our values of being able to shower ourselves and walk up and down the stairs and perhaps going shopping") can influence the team in setting goals which can seem to be the logical next step for a patient. Covid-19 here acted as a trigger for reflection on an aspect of their clinical practice that was already established as 'normal' for that team prior to the pandemic. Covid-19 also highlighted how goal setting in rehabilitation can be a process based on normative values which are not essentially person-centred, as they do not reflect individual needs and preferences. Such goals are often dominated by attainment of physical abilities which would then expedite discharge i.e. they are professional goals. Kayes and Papadimitriou (2023) term this ‘conditional’ person-centred rehabilitation:

> Professionals privileging ‘realistic’, service-centric, discipline specific goals over what may matter to the person.
>
> (Kayes and Papadimitriou 2023, p.6)

P24 alludes to this aspect of ‘pre-judging’ goals and having a set agenda without obtaining a complete picture of the patient and how they functioned pre-morbidly within their family or social microsystems:

> What were they like before their stroke? (If they never did certain things and don’t want to ever do them, there’s no point in trying to do that in your therapy). What do the people closest to them want? It’s important to try to work that out because if a partner or relative wants different things to the patient it can cause conflict – between them, and with you.
>
> (P24, online survey)

In this quote P24 highlights how collaboration and communication with all parties underpins person-centredness for them, aligning with the data in Chapter 4.

At different times during the pandemic, Covid-19 also had the effect of confining SLTs’ practice solely within the patient’s close personal microsystem i.e. within their home and within Covid-19 movement restrictions. During Covid-19, it was not possible to carry out therapy in the wider community, and for SLTs who would be likely to refer on to local organisations, the possibility to do this became limited. This is reflected in the online survey data:

> What is different is that we are more restricted with doing activities with patients outside of their homes, because of the covid restrictions. E.g. patients who have aphasia and who want to get back to their work or volunteering roles can’t do it, and it feels like we have had to leave them with part of their rehab missing, even though they are allowed to refer themselves back in the future if they want to. We used to take people to cafes and shops or on public transport, and we haven’t been able to do that.
>
> It does feel frustrating when we know that a patient would really benefit from doing something in their local community with other people as part of their rehab or stroke recovery, and we just can’t help them with it at the moment.
>
> (P24, online survey)

> I think this [PCC] has been impacted by COVID in that patients have not had the ability to go out in the community and access community events, build relationships, or see family as they would like. Goals have been centred around the patient but carried out within the service.
>
> (P78, online survey)

In the above quotes participants reflect on how Covid-19 created a ‘condensed’ version of person-centredness. This condensed version, through its restriction to certain dimensions of the patient’s microsystems, excluded the possibility of any intervention related to the social / cultural domains. Patient outcomes related to wider social and cultural identity were therefore impossible, with SLTs essentially projecting themselves, in systems thinking terms, as ‘ineffective’ actors. In Chapter 3 I explained how levers of change could be people/relationships or alternatively geographical or social spaces. The levers of change during this stage of the Covid-19 pandemic were still related to people or relationships but social spaces or places were prohibited.

In addition to confining practice to a much narrower sphere of the patient’s natural environment, for SLTs Covid-19 changed the model of direct clinical work from a person-centred approach to a more medical reductionist model. This is also illustrated by a survey respondent:

> [Covid] caused people to focus more on discrete aspects of a person or specific impairments eg reducing risk of aspiration or provision of generic support for communication difficulties instead of a personalised communication book/life story.
>
> (P5, online survey)

Person-centredness is ‘translated’ into a disease-focused model, one which reflected patient-centred care as discussed in the literature review (Chapter 2). The patient’s personhood i.e., social, cultural, psychological and spiritual needs is severely curtailed, and only biological aspects are prioritised.

Covid-19 reduced the relational way of working between the individual, their family and wider social/community settings that SLTs usually adopt and expressed in Chapter 5. Covid-19 affected some of the key elements identified by staff to be indicative of person-centred care such as collaboration, communication and time.

The pandemic served to highlight the tenuousness of PCC, and its fragility is conveyed by Nadia's choice of object (snowflake, see Figure 9, Chapter 4), one which is easily damaged:

> So that's the thing about snowflakes, you don't get two that are the same, but this just demonstrates how fragile they are and how quickly they can get damaged and melt and all the rest of it, and I just think that represents all the barriers to having that really good individualised care that we all really want, and it's just so easy for something to interrupt it and for something to go wrong, especially like in a ward setting or anywhere really.
>
> (Nadia, workshop 3, stroke rehab)

Nadia's comments exemplify how Covid-19 diminished, downgraded or even caused the disappearance of the 'softer' aspects of PCC which in reality help to humanise healthcare delivery and make it truly 'about the person' and their relationships.

7.1.2 How Covid-19 materialities re-shaped SLT practice

This section of the chapter now turns to materialism and has been strongly influenced by the health and sociology literature which has sought to ensure accounts of more tangible aspects of patient care are made visible (see Buse et al. 2018; MacDonald et al. 2018). The material aspects of patient care became very visible during Covid-19, and it is to this discussion of Covid-19 and its illumination of material aspects of PCC that the analysis turns.

The Covid-19 pandemic did not leave any part of the healthcare system unaffected. Many of these effects possessed a material form in that they can be identified as numbers, uniforms and personal protective equipment (PPE), areas in a hospital, and new forms of service delivery. Service delivery changes resulted from lack of healthcare staff across the organisation due to sickness or shielding; infection control practices such as PPE and 'zoning' patients and wards into 'clean' and 'dirty' areas; reconfiguration of space within the SLT service; and new technology such as telehealth as part of the service / organisational response to the virus. These new material aspects in effect created novel SLT relationships within their professional microsystems, and each one is considered in turn.

7.1.2.1. SLT: - Space

Space as a material element which shapes healthcare was present in SLTs' narratives. The issue of space was evident in the talk of SLTs in more than one of the workshops, particularly the effect of Covid-19 in reconfiguring space within the hospital setting. The lack of space within the SLT department impacted on staff's ability to plan therapy:

> Nancy: I know this sounds ridiculous but for me it's space. I find it really difficult in a room full of people to focus my thoughts and plan, and time is obviously another, but we don't have space within this hospital to go away and think about therapy plans for patients.
>
> Carol: Or even like having a conversation with family. If you want to have a conversation with family and find somewhere quiet, there's not always a place to do that.
>
> Nancy: And whether that be face-to-face or whether it be a telephone call then you still can't find that space.
>
> Elaine: Also with your patients. If you've got patients who can talk through it, even just finding…there's no privacy is there?
>
> Nancy: We have best interest meetings about withdrawal of care for patients in a therapy room where people are coming in to get equipment and stuff. It's just not appropriate.
>
> (Nancy, Carol and Elaine, workshop 5, acute wards)

The re-drawing of space within the hospital due to Covid-19 shaped SLT care by reducing SLTs' ability to think holistically about their patients. Lack of 'thinking space' limited not only SLT time for planning therapy but also relational work with both patients and families. Space in effect determined the boundaries of care and again person-centredness was reduced to a 'weaker' version, where contact with families and even patients was difficult, and a holistic approach to intervention proved challenging. Even end of life care, and the discussions involved in such planning, risked the patient's personhood becoming part of the more 'public' face of the ward, as competition for space exposed clinical conversations which were usually confined within teams.

Lack of space also influenced staff wellbeing, either due to relocation to new, smaller offices during the pandemic, or because the lack of space was perceived as stressful:

> I find, especially the last year and a half we don't have our offices, I find sometimes that office quite stressful and overwhelming because we're several people trying to do lots of things in the office. We don't have the environment.
>
> (Fran, workshop 3, stroke rehabilitation)
>
> I think it impacts a lot. I mean, I may be talking personally but it impacts on my ability to focus and plan my day. Almost your wellbeing within work, if you've got a really busy office and you just automatically feel a little bit like, wow. Rabbit in the headlight.
>
> (Nancy, workshop 5, acute wards)

Staff attempted to surmount the stresses of lack of space by reconfiguring the space available to promote wellbeing: "we make an effort to make the office a little bit nicer" (Fran, workshop 3, stroke rehabilitation). Staff used their own personal objects such as pictures to enhance their working environment and project their own identities on the communal working space. Materiality in this case was a tool for staff wellbeing and for their care of each other.

The use of space to enhance wellbeing resonates with Dickson and Sanders' (2022) comment:

> We believe that creating spaces for 'being still' to check in with each other, reflect, listen to understand or have critical conversations can be integrated into daily practice. In these exceptional times we believe that relationships should be prioritised to promote the wellbeing of all.
>
> Dickson and Sanders (2022, p.2).

The above quote highlights how a changed culture, with its focus on relationality and recognition of staff personhood, became a key element during Covid and thus extended person-centredness, according to definitions discussed in Chapter 2. The pandemic also surfaced the importance of relationality as a vital part of person-centredness (Edvardsson et al. 2020).

7.1.2.2. SLT: – Body work

In Chapter 5 the concept of material objects such as food and their role in everyday practices was introduced. Holmes (2019) also considers the body to be "a form of lived everyday materiality" (p.125), with daily practices such as showering, eating and personal grooming all routines associated with keeping the body functional. Holmes notes how the term 'body work' originated from research on nursing and care work (for example Twigg 2000) but has been expanded in the literature to include other forms of paid body work such as hairdressing and beauty therapy.

Body work for SLT occurred during Covid-19 due to SLT staff being asked to help with basic care on wards. This was another example of an element of the SLTs' interpersonal microsystem (in this case SLT-patient relationship) being changed and affected by organisational needs during Covid-19. Body work by staff then became another way of earning the patient's trust and potentially building the working alliance.

Being physically hard working and working with patients in an embodied way was also a way for SLTs to demonstrate teamwork with nursing staff during Covid-19. Fran reflects on a session where she has had to abandon her planned therapeutic activities and instead has showered, washed and shaved the patient:

> I felt at the time that that would, like, help me build a better rapport with him and maybe that will have, like, an impact on our therapeutic relationship afterwards.
>
> (Fran, workshop 3, stroke rehabilitation)

While Fran projects body work as a positive means of engagement with the patient, Laura perceives that providing personal physical care for patients removes the SLT from their own discipline-specific person-centred agenda:

> With all the Covid stuff there's been challenges, especially on the ward with just basic nursing care and we keep getting called in to help, don't we. It's just stripping back all those bigger things that we want to do just to try and brush people's hair.
>
> (Laura, workshop 3, stroke rehabilitation)

SLT reflections highlight how lack of basic everyday personal objects in hospital during Covid-19 impact on patients' identity and wellbeing and supporting patients with aspects of personal care help the SLTs gain the patient's trust and establish rapport. Nancy's gift of Fixodent to a patient helps them achieve a socially 'acceptable' body (or face) in spite of serious injuries and results in the patient feeling closer to their pre-morbid self.

I didn’t realise how one object could make a patient feel “so normal” again despite multiple injuries. This particular patient was unable to wear her dentures because they no longer fitted properly; family were unable to visit due to COVID. One day on my way into work I bought her some Fixodent and it was as if I’d changed her world completely – to her this made her face feel “normal again” – she was able to eat, smile and talk which made her no longer feel distant from her former self. This one act made such a difference to this lady’s day and ongoing hospital stay. One item as simple as this made this patient feel human and “normal” again and to me this was an example of patient centeredness.

Figure 22: Nancy’s image, workshop 5, acute wards

Fran’s comments indicate how normative values[20] related to appearance and body grooming, as part of body work, apply even in hospital during Covid-19:

> You have doctors and strangers talking to you and you feel quite horrid because you would never show up in front of a stranger looking like, you know, with unwashed hair.
>
> (Fran, workshop 3, stroke rehabilitation)

Fran’s choice of object (hairbrush) to represent person-centredness exemplifies not only identity expression through self-care but also demonstrates elements of emotion work with patients during Covid-19.

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[20] Holmes (2019, p.125): bodily maintenance is about conforming to societal ideals about what constitutes an acceptable body...Bodily grooming practices are one way ...the body is maintained and repaired...while also conforming to societal norms.

7.1.2.3. SLT: - PPE

While Covid-19 exposed the importance of relational processes in SLT clinical practice, practices initiated by the organisation to control spread of infection (e.g. use of PPE) impacted on and became a barrier to building relationships with patients:

> Charlotte: Yeah. Face- to- face as well with PPE. It puts the barrier between you.
>
> Stella: PPE has affected that as well.
>
> (Charlotte and Stella, workshop 2, out-patients)

The impact of face masks on people with communication difficulties post stroke has been explored by Clay and Broomfield (2022) and aligns with the data above. Masks not only affected patients' comprehension of speech by hiding facial non-verbal cues but also impacted on the patient-HCP connection and trust and thus relationship-building. This challenge is also acknowledged in an online survey response:

> The relationship between service user and health professional has been a significant challenge due to the limitations from PPE use impacting on basic communication and rapport building.
>
> (P36, online survey)

Another element of infection control, namely the wearing of specific clothing to reduce infection risk, was highlighted by P6, who was asked to work on the wards during the pandemic and who "had to start wearing scrubs which feels very medical model rather than social model". The SLT in this quote is having a more 'medical' identity imposed on them which appears to be at odds with how they would normally work.

7.1.2.4. SLT: -Telehealth

Mutuality of trust during the pandemic was also negatively influenced by adoption of technology such as telehealth by both out-patient and community staff. Technical difficulties impacted on staff's ability to create a good relationship with patients:

> I think building a rapport with patients has been more difficult with telehealth because of tech issues. So, if you're in the middle of a conversation and something just cuts out and then you're back and forth talking about the tech issues, it can interrupt the flow of it as a result.
>
> (Stella, workshop 2, out-patients)

Online respondents highlighted that patients often could not access telehealth, and that technology did not always meet patients' needs:

> As I'm having more meetings over Microsoft Teams, I am often unable to bring the client into the appointment as they are not aware of distance communication. Previously we would have broken down the choices of communication aid to two suitable options and shown them to the client to take their opinion into account. However, I am relying on others to show the client pictures and ask for colour opinions from the client; they cannot show them more about what the device can do.
>
> (P18, online survey)

In this latter account adoption of technology is not aligned with a person-centred approach as it directly conflicts with the patient's strengths and abilities (previously identified by staff as part of person-centredness, see Chapter 5). Positive reactions to telehealth, however, were also apparent in the online data:

> SLT can access more easily through online, not wearing a mask for online is helpful for communication too.
>
> (P15, online survey)

Generally, survey respondents reported a mixed reaction to the adoption of telehealth, the majority providing negative comments. However, positive aspects mentioned included easier access to families (as they were often present in the home during the SLT online session), and certain patients liking not having to travel with its reduced risk of infection.

7.2 Covid-19 and staff wellbeing

The impact of Covid-19 brought to the fore the importance and success of staff supporting each other, especially when the organisational discourse ('being called in to help') linked working overtime and 'going the extra mile' with being a 'good' team worker who supported their nursing colleagues:

> It comes back to the system and that pressure that is put on us as well to do the extra shifts and I know you'll always say: oh, I feel really bad. Shall I do an extra shift? You're the first one to say that and it is that burnout then though as well for staff because we need to be person centred with yourself to be able to do really great person-centred care day-to-day as well. To have that energy and that motivation, that positivity to keep going.
>
> (Nadia, workshop 3, stroke rehabilitation)

Nadia here not only connects person-centredness with staff well-being (in addition to patients' wellbeing) but also associates self-care with the ability to provide person-centredness in practice, aligning with Kayes and Papadimitrou (2023). In Nadia's quote there is clear tension between personal values and the organisational discourse linked to particular materialities created by Covid-19. The issue of self-care evident in Nadia's comment is also highlighted in Lily's choice of image (a fox, see Figure 7, Chapter 4) to represent person-centredness:

> The tail [of the fox] I thought is that thing that is, like you say, it's important to be able to protect yourself as well, because that's what they do isn't it? When they curl up, they have that enormous fluffy tail that keeps them safe, and you do need that.
>
> So that furry tail is that thing to actually protect yourself whilst you are being in that position where you're trying to be alert and very giving and responsive to other people's needs as well. So, I think that's why I chose the fox.
>
> (Lily, workshop 3, stroke rehab)

Despite the institutional demands of Covid-19, staff were able to buffer against its worst aspects through caring for themselves and each other. Close team familiarity, in association with personal support for colleagues, has been shown to lead to staff feeling a sense of belonging in their team (see Gordon 2020). Ewen (2021) also notes how supportive relationships foster SLTs' resilience in the face of workplace challenges. Staff peer relationships fostered their own and colleagues' emotional wellbeing, an element which was foregrounded and made visible by the pandemic

> With Covid, people had, like, different worries about different things and I had, like, my own personal worries and I think if I didn't have my team, I don't know, I think my mental health would be significantly worse if I didn't have such a lovely team. It's very important.
>
> (Fran, workshop 3, stroke rehabilitation)
>
> I think wellbeing is key. We are such a close team in the sense that we spend so much time together and work is such a huge part of all our lives. I think we're really lucky in the sense that we all get on very well and we all look out for each other and we all, kind of, identify when someone is not quite right and things like that.
>
> (Nancy, workshop 4, acute wards)

Data from the online survey also highlighted challenges SLT staff faced in managing their own emotions and that of their colleagues. P32 notes that “staff are very tired / emotionally drained” while other online respondents record their struggle to maintain wellbeing and resilience:

> Focusing on just getting through the day. Needing to focus on our own wellbeing – less to give to others.
>
> (P30, online)

> Staffing issues such as redeployment, shielding and sickness impacted on SLT’s input and those therapists that were left were sent to ward cover. These therapists have been left tired and drained. Therapists were put in unfamiliar settings with change in support structures which further impacts on staff’s resilience.
>
> (P58, online)

Staff’s emotional labour was directed not only towards patients but also towards themselves and their colleagues. This mirrors one of the key findings of Riley and Weiss’ (2016) qualitative thematic review of studies exploring sources of emotional labour in the daily work of a variety of healthcare staff (although the majority are nurses) working in different healthcare settings. Their findings though relate to stressful situations in general and not Covid-19.

The next section moves the analysis from staff wellbeing to how staff supported patients’ wellbeing during Covid-19 through their bridging work with families.

7.3 SLT as a social bridge

Although this section is concerned with connections within the patient’s interpersonal microsystem, namely SLTs’ role in linking patients and families during Covid-19, it came about due to significant disruption at the organisational level i.e. Covid-19. I propose that SLTs acted as a social bridge within this interpersonal microsystem and that this bridging work was an extension of the emotional labour that SLTs usually perform with patients. SLTs help the patient and significant others adjust to living with a communication disorder (e.g., aphasia); the aphasia literature highlights the negative emotional effects on both patients and families, with depression being especially prevalent. Northcott et al.’s (2018) study into psychosocial support provided by SLTs highlights a lack of consensus among SLTs as to scope of their role, but participants report carrying out “counselling-type interactions, psychoeducation, working with families, facilitating peer support, and training other healthcare professionals” (p.2).

SLTs’ bridging role between patients in hospital and their families brought to the fore the patient as a relational being embedded within their own interpersonal microsystems. Relational aspects such as the patient’s social connections and personal microsystems were highlighted and prioritised. This emphasis on reaching out to families was prominent in the talk of SLTs working in hospital settings:

> I think without family in at the moment it’s more important than ever. Just that we are there as their link**.** That there is somebody that they can reach out to, they contact us, and we will listen because they don’t have visitors every day.
>
> (Laura, workshop 3, stroke rehabilitation)

Here Laura is demonstrating active listening which aids getting to know the patient as a person, while also acting as a source of patients’ community and connection in their own right. There is recognition of the person as part of a wider social group or network and SLT is actively facilitating that connection to their community. This link to families also served to aid SLTs’ rehabilitative role by enhancing patients’ wellbeing and motivation:

> Through Covid obviously people hadn’t been able to have access to family and family not being able to visit and I think part of our role shifted a little bit into giving people that connection to their family. So, either through holding a phone to people’s ear to help them call their family or facilitating a Facetime call. I think we’ve all done that pretty much and it helps people to, you know, families are quite motivating for people. So, I think it helps with our care and our rehab that we give them, and I think it’s very person centred because it’s all to do with their roots, their family and us supporting their connections with the family**.**
>
> (Carol, workshop 4, acute setting)

Carol is associating PCC with relationships, particularly SLTs’ focus on preventing erosion and sustaining growth of close personal relationships (see Fotidaou et al. 2014). Carol’s viewpoint of families impacting positively on rehabilitation is echoed by survey respondent P40, a SLT working in Critical Care who reported involvement with a woman with a tracheostomy. Part of the SLT’s rehabilitative role is to enable this patient to produce voice, and once this is achieved, the role shifts into facilitating Facetime connection between the patient and their husband, also admitted with Covid-

19. This regular sensitive advocacy has the effect of boosting the individual's morale and motivation and indirectly supports the rehabilitation process.

Research shows that patients with strong social networks or family support have better clinical outcomes from the rehabilitation process. Improved outcomes are based on family as a resource, which can be both enabling (Rassmussen et al. 2019) or even disabling (Bezmez et al. 2021), depending on the family's cultural background. Family support and active involvement in rehabilitation has also been described as a form of 'rehab capital' whereby distribution of professional resources and decision-making are able to be mobilised (Guldager et al. 2018). This is particularly the case when patients have cognitive or communication difficulties.

SLTs were moving back and forth between their professional rehabilitative role and the role of 'social bridge' which was thrust upon them by the circumstances of the pandemic. The 'social bridge' built by SLTs brought to light and extended SLTs' key role in communication, where SLTs literally facilitated direct communication between the patient and others (e.g. families or other HCPs).

In addition to facilitating connection with families, SLTs also acted as proxy family for some patients, as evidenced in Carol's reflection about a patient:

> He just wanted to have conversations. He just wanted quality communication with people and obviously his family couldn't come in. So, he was looking for that from the staff.
>
> (Carol, workshop 4, acute setting)

In the context of Covid-19, PCC highlights the key roles that significant others play in maintaining patients' health and wellbeing. Nordqvist (2019) draws on the work of Bengston et al. (2002) in discussing how "relationships matter deeply in people's everyday life, forming the backdrop for how people live their individual lives" (p.46). Significant others may extend beyond immediate family, encompassing friends and individuals within a person's 'personal community', encompassing a network of social ties (Spencer and Pahl 2006). This community can include members of different relationship categories such as family member, acquaintance, friend or work colleague as boundaries between them are often blurred (Davies 2019).

The SLT narratives recognised the psychological impact of this link on patients' wellbeing, as survey respondents noted:

> Communication has become more of a focus /priority as families have not been at bedside to advocate for them and being able to facetime/ring families has been one of the biggest motivators for some patients!
>
> (P40, online survey)

> Having no visitors (family or friends) has greatly limited a person's access to the things that (often) matter the most.
>
> (P43, online survey)

> People are not living normal lives. They are not seeing those who are important to them and dealing with situations which necessarily challenge their speech and language. Mood has often been low.
>
> (P4, online survey)

These narratives illustrate that SLTs were aware of disruption caused, not only by impaired communication skills but also that people's usual emotional support mechanisms of family and friends, were not available. The importance of the social bridge also relates to its link with 'normality' where the patient is a person and not just person-as-patient, as often configured in healthcare interactions.

The clinical vignettes and staff observations highlighted how SLT practice was reconfigured during the Covid-19 pandemic. The usual focus on relational practice, involving collaboration and communication with families, was extremely challenging. SLTs were unable to work with patients in their wider community microsystems and instead therapy was constrained to either the patient themselves or immediate family. In addition, the organisational priority on discharging patients home rapidly prevented a truly holistic, person-centred approach which focused on each person's unique needs.

Olson (2022) argues that emotions "connect some individuals through social relations" (p.64) and the 'bridging' work of SLTs within my study is underpinned by such emotion management. The new roles of 'bridging' and 'substituting' highlighted through my analysis are also evident in Dowrick et al.'s (2021) empirical study into how healthcare is re-ordered secondary to Covid-19. Their study explores particularly how emotion management is affected by the re-configuration of interactions through situating care as a form of ‘affective practice’ (drawing on Puig de la Bellacasa 2011) where the relations of care are shaped by emotion.

Dowrick et al. (2021) state that the infection control measures implemented specifically for the pandemic as well as the virus itself (‘dirty’ versus ‘clean’ spaces) transform “the materiality of hospitals as an assembled network of relationships between people and things” (p.2170) so that any interaction during care itself is re-configured. It can also reconfigure professionals and patients within PCC. Emotion management by staff is extended to include patients’ families and the authors posit that these new roles which have been thrust upon staff demonstrate that they are ‘stewarding the ‘humanity’ of care’:

> Through affective practices which aim to connect with, rather than distance from those they cared for, they enact a social order which centres compassion.
>
> (Dowrick et al. 2021, p.2170)

Emotion management therefore assumed even greater importance during the pandemic. My analysis shows that Covid-19 served to shape and extend usual SLT roles and practice (and that of other HCPs) and made more visible emotional care centred around patients and families i.e., connecting with their personal microsystems became one of the highest priorities for each patient. As already discussed, re-configuration of space affected staff wellbeing and resulted in SLT’s emotional gaze also being directed inwards towards self and colleagues, with collective care prominent in the talk of SLTs at this time.

As Olson (2022) states, “all care involves emotions” (p.64) and emotional labour is a key element within healthcare:

> All carers work to manage their own and the patient’s emotions to comply with cultural and organisational expectations and respond to the challenges that come with a diagnosis or disability: grief for unrealised plans, and a revised temporal and emotional orientation to the present and future.
>
> (Olson 2022, p.64)

Emotional labour in healthcare is acknowledged as the recognition of emotions in others and as part of the act of caring, which also “requires skills and resources to care” (Riley and Weiss 2016, p.6 drawing on Smith 2012). The skills and resources necessary to carry out this type of work are crucial when interacting with patients with communication problems. Giving patients a voice or providing them with a means of communication can be argued to be a particular form of emotion management during Covid-19, to facilitate and support interaction with their loved ones.

Moss et al.'s (2021) study into adjustment post stroke and aphasia also highlights that emotion management is vital and valued by patients and families, and connection with social networks is essential to adjustment. This focus on connections is brought to the fore by Covid-19 and is evident throughout my data.

During the peaks of the pandemic, a certain kind of clinical practice was created, one where the onus was on physical care tasks. It can be argued therefore that Covid-19 often reduced person-centred practice to patient-centred care, especially when the patient's wider needs i.e. personhood, and the needs of their families were omitted from consideration.

7.4 Chapter summary

This chapter has highlighted how materialities and discourses of Covid impacted upon SLTs' clinical practice. Physical needs such as swallowing became prioritised over patients' communication and social needs, but communicability became even more important for patients to express emotional needs.

Lack of contact with family and friends affected patients' wellbeing and motivation, thus necessitating SLTs' new role of 'social bridge' in facilitating Facetime contact with patients' families and extending SLTs' usual emotional labour with patients. SLTs themselves, like other healthcare staff, experienced issues with morale and resilience, and their emotional labour was extended to include themselves and their colleagues. This self-care was perceived by staff as a vital facilitator of person-centredness in their clinical practice. Emotional labour to self, peers and patients then became a key part of SLTs' professional practice during the pandemic.

To return to the SEM, the effect of the pandemic transformed all levels, with changes evident both within and across levels. For example, staff's fears and anxieties within their own intrapersonal level; SLTs' relationships within their interpersonal microsystems not only changed but new microsystems such as space and PPE were created.

In this instance the idea of materiality originates at the organisational level of the SEM (previously noted as part of the interpersonal level in Chapter 5). At this level SLTs become part of the system, for example, they created space by facilitating patients' discharge from hospital. However, they were themselves impacted by changes in space secondary to Covid-19; materiality here resides at organisational levels and below and surfaces SLTs' relationships within these levels. Changes in materiality which constituted novel relationships or microsystems for SLTs, such as space, PPE and tele-health, were a feature of the organisational level but ultimately affected SLTs relationships with patients and the care that they were able to deliver.

At the organisational level, institutional drivers were amended secondary to the virus. These altered organisational drivers then directly affected the levels below and their demands superseded person-centredness. They can be equated to shadow elements (see Chapter 3) which served to diminish person-centredness and make it less visible.

The stress caused by Covid-19 exposed the dominance of the biomedical model operating in many clinical contexts, with the dominance of this model during the pandemic limiting the PCC that was achievable for SLTs. Covid-19 turned out to be a powerful example of the stresses that the NHS is under; close analysis of SLTs' experiences during this time revealed their capacity to deliver PCC was linked to the need to recognise the relationships between all levels identified in the SEM, and how positive relations shaped positive PCC practices within the delivery of healthcare.

SLTs talked about how their identity as 'good' healthcare professionals willing to step outside their own professional role, was driven by and in response to Covid-19, as part of a willingness to maintain organisational function during a time of crisis while performing their SLT professional roles. However, the pandemic also brought many material challenges, from changing roles to working with PPE, that impacted on SLT practice. The SLTs argued how this could exacerbate existing tensions between personal values and expectations of organisational systems, but also how creation of good supportive teams in SLT acted as a buffer against its worst effects.

Like the previous chapter, this chapter also addresses RQ2 by highlighting both positive and negative elements impacting on PCC during Covid-19.

Figure 23 summarises the findings at the different levels of the SEM:

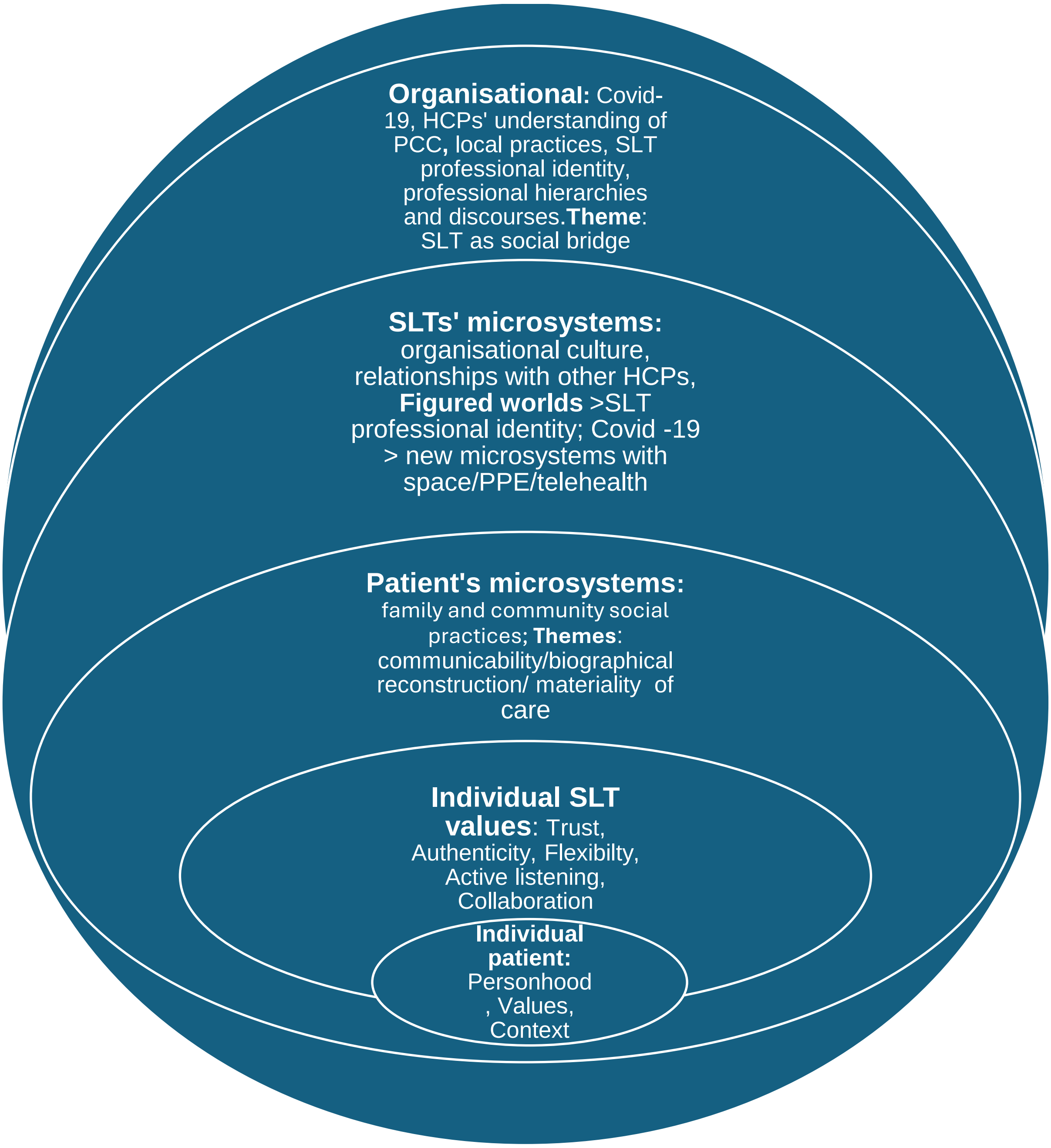

Figure 23: summary of findings at different levels of the SEM

Chapter 8: Discussion and Conclusions

The major thrust of this thesis has been to examine the contribution of PCC to SLT practice, and how particular PCC practices, values and expectations in professional-patient relationships contribute to the production and reproduction of care across all levels of the socio-ecological relationships described by Davidson et al. (2018). Although the study was initially conceived to explore PCC across different SLT contexts of intervention – acute wards, rehabilitation (brain injury and stroke), out-patients and community, the development of this thesis during a global pandemic necessitated a more focused approach, drawing on how socio-ecological relationships were disrupted and/or reshaped. More specifically, it required a methodology that linked practice, care, and relationships, within a period when analysis of affirmative connections between these aspects are most usefully made.

Socio-ecological models have informed the structure and much of the thinking that constitutes the argument of this thesis, particularly the idea of PCC as relationally and contextually produced ways of practice and being. Drawing on SEMs adapted from Bronfenbrenner (1979), socio-ecological theory has made it essential to examine the constitution of PCC in and through the understanding of multiple levels and relationships. Similarly, to interpret the PCC meaning-making actions of SLTs it has been necessary to identify those positions and actions from the roles they embrace in their different professional contexts. Analysis of PCC contribution to health services, professional practice, patient outcomes and the intersection between all three, has been important to explain in the literature review: it therefore provides an explanation and a rationale for how socio-ecological thinking has structured the thesis.

8.1 Research questions revisited

An important motivation for the research questions generating this thesis has been a concern to challenge taken-for-granted practices and understandings of SLTs, in affirmative and reflexive ways that do not undermine current practice. This thesis aims to provide the means by which SLT as a profession (comprising different subgroups and skills) can begin to examine how PCC contributes to practice and relationships, and how these, in the context of healthcare services and discourses about PCC, shape and even limit SLT. The research questions informing this thesis are:

RQ1: What is SLTs' role within PCC and how do their values shape their practice and professional identity?

RQ2: What are the processes that facilitate or hinder person-centred practice?

RQ3: How can SEM contribute to our thinking on person-centredness within SLT clinical practice?

RQ4: How can the methodological approach of Appreciative Inquiry be used to explore SLTs' conceptualisations and practice of person-centredness?

The task, then, in this conclusion is to explain how each of these was met, and to work towards an in-depth understanding of PCC in the context of SLT and a global pandemic. The findings of the research questions are explored below. In the final sections the discussion moves to exploring new possibilities for PCC that contribute to new understandings of SLT practice as 'fundamental sites' of PCC within healthcare settings. By 'fundamental' the thesis seeks redefinition of PCC, not as a defining set of tasks, actions or values, but as something that offers up opportunities for understanding and opening up relationships for all HCPs across a health service 'ecosystem'; responsive to patients' social, biographical and affective needs, but also challenging hierarchies of regulating and resourcing PCC, with effort directed into policies and professional standards.

8.1.1 RQ1: What is SLTs' role within PCC and how do their values shape their practice and professional identity?

The review of existing SLT literature on PCC revealed that studies had mainly adopted quantitative approaches to explore SLTs' attitudes to PCC and / or were confined to certain clinical contexts when exploring actual practice. To effect change in the experience and understanding of PCC by SLT, a broader qualitative study including SLTs across all clinical contexts was required.

The wider literature review confirmed the sheer volume of existing publications on PCC, concluding that there were many definitions and noting several frameworks that can be used to inform thinking around the concept of PCC. The review concluded that existing socio-ecological models adapted from Bronfenbrenner (1979) are an excellent starting point to expand on one emerging theme from the literature, i.e. that PCC is a relational concept. The evidence for the inherent relationality of PCC is the finding that the relationships between practitioners and patients was meaningful for care and that it would be represented across various organisational levels – also called a socio-ecological system. As noted in the literature review by several authors, the SEM suggests different ways and contexts for understanding healthcare. However, the analysis of PCC within this framework is limited to Woolcott et al.'s (2019) model which combines Bronfenbrenner's (1979) social ecology model with a social network analysis. This extension allows illumination of horizontal and vertical pathways across and between health systems. Phelan et al. (2020) also advocate use of a SEM to implement person-centredness in healthcare contexts.

The starting point for the account of SLT understanding of PCC is the SEM of Davidson et al. (2018, adapted from Bronfenbrenner (1979), Figure 24). This model of healthcare allows recognition of the social relationships between elements of the health system, and those which extend out into the community and beyond.

The findings from this thesis indicate that PCC should be considered deeply relational but the findings are not arguing particularly for or against PCC as being understood across all levels in the same way, or to propose specific practices and roles at each level; the participants did not present their understandings of PCC as related to a particular level, but gave mixed and integrated responses throughout. However, using Davidson et al.'s model to conceptualise SLTs' understanding of PCC, then what is meant by PCC changes at each level. Thus, the issue of PCC must be addressed at *all levels,* including the ones at which practices and professional roles appeared particularly pertinent to SLT i.e. swallowing, communicating, managing biographical disruption.

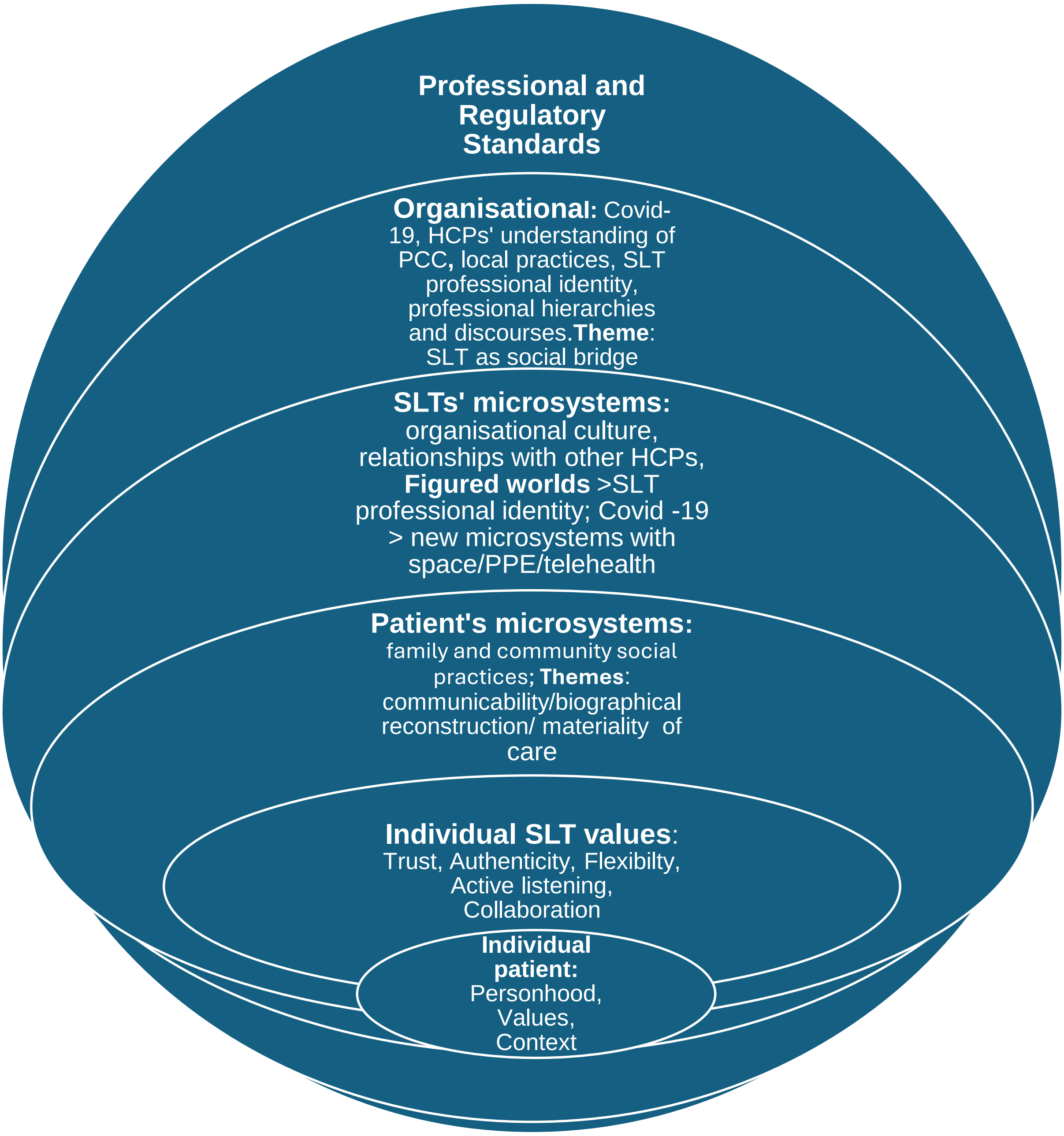

Figure 24: summary of findings at different levels of the SEM.

The long-term purpose of the thesis is to provide evidence for the socio-ecological framing of PCC which explicitly challenges the singular, fixed understanding of care focused on patient outcomes, and showed that for SLTs it is about values. In particular, in this value-based conceptualisation of PCC, the analysis showed that SLTs constructed PCC in relation to the following values:

- **Trust** between the patient and SLT, as a basis for building their therapeutic relationship. The relational framing of socio-ecological thinking showed how trust was valued primarily between the patient and the professional, but also across different levels of organisation and practices, including the practitioner knowing what tools to use and their ability to use them effectively to meet the patients' needs.
- **Authenticity** was linked to sharing their own personhood with the patient; this interconnectedness is argued to reflect meaningful engagement with the patient (Espie et al. 2021) and an indicator of person-centredness (Buetow 2016).
- **Actively listening** to the patient, to gain understanding of their life story, social and cultural contexts, in addition to biological dimensions i.e., knowing the patient's personhood and values through their narrative (aligns with Tyerman 2018; Forsgren et al. 2022).
- **Flexibility** – SLTs considered flexibility to be responding to the patient in the moment i.e., not being bound by pre-determined actions, which they deemed reflected a more humanistic approach (aligns with Mitchell et al.'s (2022) argument for a flexible approach to person-centredness, with the person and the context determining the approach).
- **Collaboration** with patients and families; sharing of information to enable patient agency in care decisions (see Waters and Buchanan 2017; Sturgiss et al. 2022).

However, this thesis argues strongly for a more reflective and critical methodology on the part of practitioners and health organisations to elicit concepts about PCC in SLT practice across levels. Appreciative inquiry provided a model of reflective practice and a methodology which could be developed to enable SLTs to more readily reflect on PCC especially in the context of work pressures in the NHS. It enables them to take more ownership of the ways in which their capacity to understand and enact PCC is shaped by their relationships, and those which they do not have access to or may be excluded from i.e. in reference to the hierarchies that were mentioned in the analysis of Chapter 6.

In addressing the methodology used for this study, the initial workshop activities i.e. visual inquiry (images / objects) and generative thinking (cake metaphor) stimulated group dialogue which surfaced these important values which SLTs considered essential to their practice (Chapter 4). Also apparent at this intrapersonal level of analysis was the relationality inherent in PCC, aligning with Edvardsson et al. (2020) and which was highlighted by the visual method adopted. SLTs' choice of images revealed their construction of the patient as a relational being situated within a particular socio-cultural context. Such a conception contributes to understanding that the intrapersonal level of PCC is important, something that the SEM studies included in the literature review underplayed. However, the importance of HCPs' values in influencing PCC is noted by Brown and Mountain (2021) (see Chapter 6).

SLTs' personal and professional values played a key role in their construction of person-centredness and provided the staff with a professional identity as person-centred practitioners. These values were challenged during Covid-19 when SLT work was re-shaped to meet organisational demands and tensions arose between personal values and organisational pressures. However, the analysis of the data generated in this thesis would want to argue for building substantial changes in what we understand as the necessary relationships for PCC, to bring about supportive and positive change to clinical practice that benefits the patient.

SLTs' stories in Chapter 5 (interpersonal level) showed how their care radiated out from the patient and immediate family into their community microsystems, emphasising the patient's social roles and connections. In this way SLT intervention targeted biographical reconstruction for the patient and reconfiguration of communicative identity within everyday activities (see Harvey (2018) concerning the importance of everyday life in rebuilding identity).

Covid-19 highlighted the roles of SLTs and how these were reshaped by the pandemic. In the context of Covid-19, SLTs' comments on person-centredness changed to include their own personhood, especially evident in Chapter 7. It is likely that Covid-19 changes contributed to understandings of PCC at different levels, about where it was lacking or radically altered, and that pressures on health services (and SLTs) resulted in challenges in facilitating PCC at all levels.

Affirmative perspectives about PCC in SLT require paying attention to both the professional and patient as persons, rather than viewing the concept as a single overarching narrative that excludes personhood (a concept embedded in the actual term PCC). PCC emerged as a historical and cultural construction conceived primarily within a narrow domain of health care practices and relations. However, in the workplace context, personhood is perhaps better considered as a professional identity, related to productivity and wellbeing. SLTs' reflections on their own wellbeing were "not for their own sake, but to remain productive employees" (McCool 2024, p.18) as they situated their wellbeing narratives primarily in the context of enabling them to give more to patients. As a result, the discourse of PCC in institutional contexts has not always been a complete narrative; one that is not responsive to proposed regulatory changes (HCPC 2024) which imply that wellbeing is seen as a personal project, and about which McCool (2024) voices concerns.

McCool confirms the importance of context and culture in staff wellbeing and draws on Ewen's (2021) work who states that SLTs often feel undervalued by colleagues in other professions (echoing Chapter 6). Further, McCool (2024) draws attention to the "additional demand [on wellbeing] that also comes from the relational nature of SLT. It brings us close to human fragility and vulnerability in all its rawness" (p.19). This vulnerability is evident within patient stories narrated by SLTs.

Chapter 7 highlights SLTs' relationships with colleagues and employing organisations during the pandemic, and how staff personhood was easily 'lost' through demands to work extra hours or additional roles, unless buffered by peer emotional support. Indeed, Armstrong et al. (2020) note how "COVID-19 is an interconnecting, cascading tsunami of up rootedness, loss and change on many levels" (p.2). This loss also affected patients in hospital, where SLTs' unique role in communication expanded into becoming a social bridge with patients' families; this continuation of social links for the patient ensured some continuity of the patient's personhood by SLT.

8.1.2 RQ2: What are the processes that facilitate or hinder person-centred practice?

As the approach used in this thesis began to cultivate a deep understanding of PCC for SLT, the challenges and difficulties of maintaining PCC became apparent, even within the context of it being framed as an institutional need (by the NHS and professional bodies) and the professionals themselves. The thesis analysis revealed a number of challenges for the SLTs in maintaining PCC.

Analysis in Chapter 6 using figured worlds theory uncovered a wider set of relationships pertaining to professional hierarchies, culture and power, with SLTs' professional skills not always valued by colleagues. Socio-ecologically focused analysis showed the particular relations that were important in healthcare, both within and external to its systems, and as McCance and McCormack (2023) stress, person-centredness is "translated through relationships" (p.1). SLTs' critical relationships, however, often impacted on PCC and undervalued SLTs' professional identity. Jowsey et al. (2020) argue that values are aligned with professionalism and thus professional identity, enacted through relationships:

> Healthcare professionalism is a demonstration of essential values enacted through personal professional behaviours and relationships: caring for and respecting patients, acting honestly and ethically, working in partnership with patients and colleagues.
>
> (Jowsey et al. 2020, p.11)

Professional relationships impacting on SLTs' values therefore resulted in tension between team members and surfaced as shadow elements hindering SLTs' version of PCC.

Political and economic influences (macro level of SEM, Figure 25) also need consideration due to their power and control within and external to healthcare. Workshop participants alluded to this influence when they reflected on 'fighting every policy' to action person-centredness (Chapter 6). McCormack et al. (2021) emphasise that person-centred clinical practice "needs to embrace a variety of individual, personal, contextual and political attributes that shape how we provide healthcare" (p.16). Socio-ecological analysis highlights the interaction of these different levels and how they shape individual SLT practice.

SLTs may, and do, resist being positioned by hierarchies in health care. This resistance may take the form of avoidance or frustration. They may obstruct their own ability to deliver PCC by using the less restrictive relationships and to accomplish the kind of SLT practice that they feel makes them a good professional. Thus, the AI methodology did enable the analysis to introduce a power/hierarchy relation in which they have some capacity to deliver PCC, effectively or on their own terms. However, this may be counterintuitive in relation to it being valued or valuable elsewhere in the institution, through their positioning by others in the hierarchy of the levels on which the analysis drew. Conversely, the methodology of AI brought SLT in dialogue with each other and in relation to their own practice in creative ways, which reinforced what they were able to do and what they did do in delivering PCC.

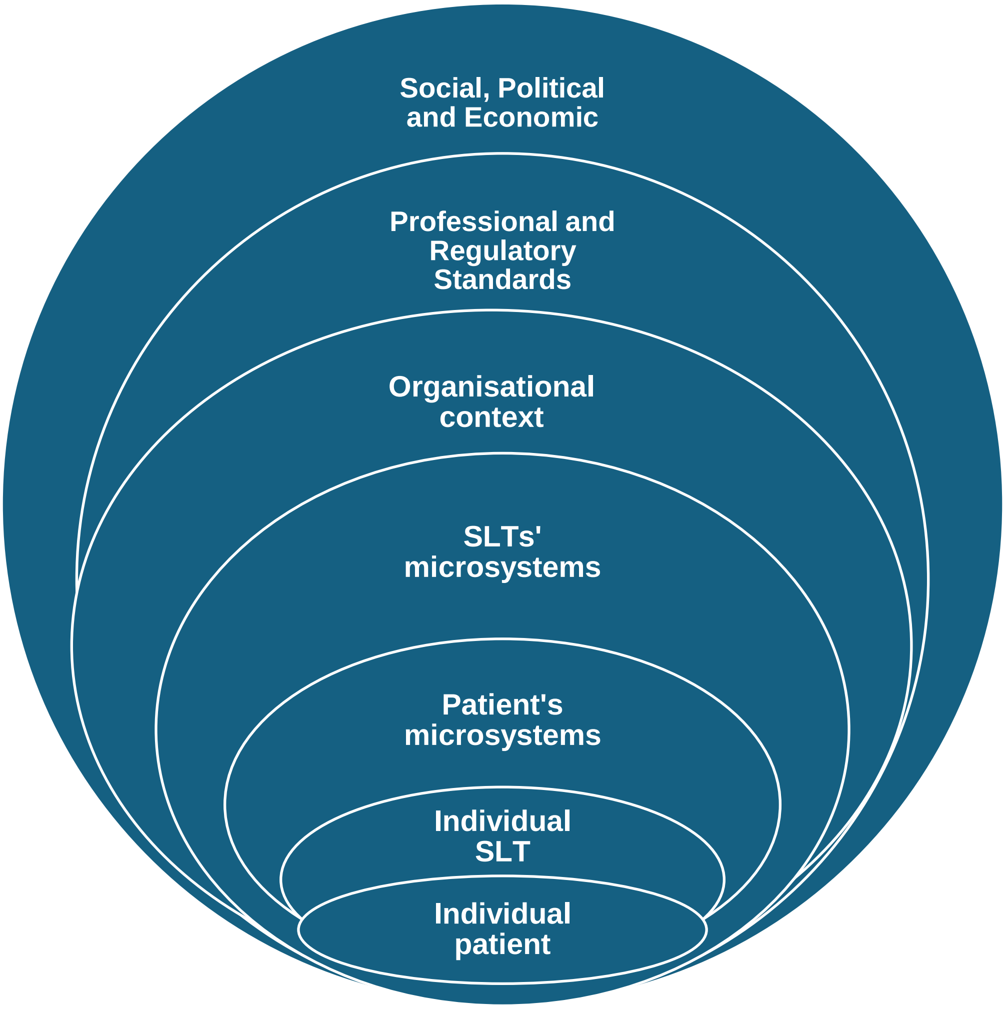

Figure 25: SEM showing macro level

8.1.3 RQ3: How can the SEM contribute to our thinking on PCC within SLT clinical practice?

Analysis using the SEM in this thesis opened up the opportunity to think about SLT as part of a system of social and institutional relationships and to think across levels from the intrapersonal to the organisational - all of which helped to show what was important for PCC at each level, for the interests of SLT, but also for the needs and interests of patients, as well as the wider healthcare service.

PCC for SLTs included not only the patient's relationships with people, but also other elements such as food and socio-cultural context. SLTs' stories revealed these as particular relationships for the patient, at both intrapersonal and interpersonal levels of the SEM. Socio-ecological analysis begins to show how clinical practice can be shaped through a conceptual approach, but any change in practice is reliant on SLTs understanding how their practices contribute to the construction of PCC and its relations.

From the socio-ecological analysis SLTs emerge as a conduit between the inter-play of different healthcare levels; they are active agents that support co-existing microsystems (patient-family; patient-community; patient-food). They utilise levers of change based on relationships, communicability and food to ensure patients' lives are meaningful. SLTs move between the social and medical relationships of patients' everyday lives and demonstrate the value of more biocultural ways of 'doing' health care - encompassing the biological/physical and social/cultural dimensions.

8.1.4 RQ4: How can the methodological approach of Appreciative Inquiry be used to explore SLTs' conceptualisations and practice of person-centredness?

The combination of my professional role and my affirmative and creative approach with the methodology did enable me to actively pursue data collection during the pandemic. At this time, AI as a methodology assumed a greater importance as it allowed staff space to reflect on their own practice and wellbeing (also reflected in the literature – Chapter 2). The PCC defined in and through the context of the pandemic is far more open and reflective for SLTs than the literature proposed. According to the methodological literature review, AI is refreshingly assertive but claimed to be overly optimistic (Fitzgerald et al. 2010) but in this thesis, PCC has both critical and conceptual depth, and is practitioner and patient focused.

The methods employed (visual inquiry, use of cake metaphor and AI workshop) enabled me to draw out not only perceptions and understandings of PCC by individual SLTs but to allow co-construction of local knowledge based on their clinical practice i.e. a true participatory approach. SLTs' positive patient stories highlighted their practice of PCC, while the online survey enabled access to SLTs across the UK working in a variety of clinical settings and their collated responses extended the data collected. The methodology also revealed unintended negative consequences of healthcare practices during Covid-19 such as increased risk to patients secondary to speedy discharge from hospital, and SLTs' inability to access patients' community microsystems.

AI relied on staff and their engagement; that afforded opportunities for development of critical and reflective awareness in ways that were not pre-determined. Similarly, use of AI techniques in the survey allowed for less standardised survey methods that produced creative and engaged responses. While the survey format was more restrictive, SLT practice and the ways in which SLTs work are ways that lend themselves to creative and reflexive activities and suggest that this method may be a good approach to use for understanding developments in PCC or future pressures in health services.

8.2 Further theoretical and empirical contributions

Theoretically and empirically, this thesis contributes to SLT, healthcare and sociological literature. Conceptually, by relocating the concept of communicability from the deaf/hearing dichotomy to the articulate speech/no speech binary, it highlights the importance of communicability as a key element in making patients' lives meaningful: the ultimate aim of PCC. Similarly, communicative identity within biographical reconstruction supports patients' social routines and practices, while tinkering or adaptation of food or drink textures influences the intrapersonal and interpersonal levels of the SEM and thence PCC in practice. These three concepts illuminated *what* SLTs do in PCC and *how* they do it – this is lacking in SLT literature currently.

As described in Chapter 2, previous studies of PCC in SLT have concentrated on specific practice contexts (world-wide) or have been quantitative in nature. The novel methods in my study allowed reflections of individual SLTs and qualitative data covering different clinical settings across the whole of the UK. My data offers a fresh window into the profession's understanding and practice of PCC in the UK, within the constraints of the NHS, at a time of crisis. The thesis demonstrates new learning concerning the construction of PCC by individual SLTs through its qualitative focus while highlighting their role in PCC through stories about practice.

My data also highlights how lack of consensus on PCC within teams and organisations results in different applications of PCC, causing tension within teams. The application of figured worlds theory also exposed how organisational and professional issues of power impact on SLT roles in PCC.

8.3 Strengths and limitations

The design and execution of this single case study of SLT, supported by data generated at multiple sites of SLT clinical practice, extending via survey to SLTs throughout the UK, can be considered a strength. The impact of Covid-19 on the study's organisation / flow could be considered a limitation, but this also proved a strength as it gave insight into the changes produced within the system secondary to the stresses of Covid-19. The limitations of the biomedical model became more evident at this time of crisis when PCC was reduced. The AI methodology surfaced the risks associated with a pure biomedical model of healthcare delivery, compared to the nuances of PCC provided by SLTs moving between and within systems.

Covid-19 also highlighted the importance of staff personhood and wellbeing in the ability to provide PCC. My research therefore supports and contributes to emerging ideas about healthful cultures (introduced in Chapter 2) and their necessity for supporting personhood of both patients and HCPs in PCC.

The idea of relationality is important for understanding how PCC emerges as part of socio-ecological thinking. The concept of relationality is not explicit in all academic accounts of SEM and this thesis finds that relationality is an area for further development of socio-ecological thinking, in particular more in-depth engagement with relationality as a concept that has different understandings in the social sciences, systems thinking and the professional literature. The type of relationality I am using is influenced by Crossley (2011, 2015) but my engagement with relationality is somewhat preliminary (due to time constraints in the thesis).

8.4 Implications

This thesis therefore has implications for SLTs, HCPs, health systems and policies. Analysis shows that PCC needs to be understood in the same way by all involved in healthcare – from policy makers downwards. Context may shape its operationalisation at different levels, but the core elements of PCC remain the same i.e. relationality and personhood. My data also surfaced SLTs' beliefs that different healthcare professions conceptualise PCC in diverse ways and supports previous work by Rosewilliam et al. (2019), suggesting a need for work on PCC within healthcare education. SLTs' feelings of being undervalued and their positioning hierarchically within healthcare teams would also suggest further research on SLT professional identity within healthcare systems and its influence on PCC.

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Appendix 1 – Literature search terms

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Concept 1	(“speech and language therap*” OR “speech -language therap*” OR “speech-language path*” OR “speech and language path*” OR “speech therap*” OR “speech path*”)
2	(“person cent* care” OR “person-cent* care” OR “person cent* practice” OR “person-cent* practice”)
3	“appreciative inquiry” OR “appreciative enquiry” OR “appreciative action research”
4	(“soci*-ecol* model” OR “soci* ecol model” OR soci*-ecol* framework” OR “soci* ecol* framework”)
5	(Covid OR “Covid-19” OR pandemic OR Coronavir*)

Appendix 2 - Glossary

Abbreviation	**Meaning**
AI	Appreciative Inquiry
AR	Action Research
HCP	Healthcare Professional
HCPC	Health and Care Professions’ Council
IDT	Inter-disciplinary Team
MDT	Multi-disciplinary Team
PCC	Person-centred Care
PCP	Person-centred Practice
PPE	Personal Protective Equipment
RCSLT	Royal College of Speech and Language Therapists
SEM	Socio-ecological Model
SLT	Speech and Language Therapist/y

Appendix 3 - Participant Information Sheet

Exploring speech and language therapists' (SLTs) understanding of person-centred practice using appreciative inquiry.

Participant Information Sheet

This study is undertaken as an educational project and the results will be part of a thesis submitted to Cardiff University School of Social Sciences for a Professional Doctorate in Health Studies. Please read this information sheet carefully before deciding whether or not to participate in the study. If you decide to take part, before you consent you will have an opportunity to ask questions about the study and your participation in it. The study will be discussed at a service meeting and also individually with staff if required. If you decide not to take part, there will be no disadvantage to you of any kind. If you subsequently change your mind and wish to participate then there will be an opportunity to do this also.

What is the aim of the study?

Healthcare provision is considered to be excellent when it considers the individual's own values, beliefs and social and cultural context (The Health Foundation 2014). This is known as 'person-centred care' or PCC.

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The main aim of this study is exploring understanding of the concept of PCC by SLTs and in particular how it is enacted in everyday practice. The expertise of staff will be utilised to explore this topic in depth which will then enable improvements in practice. The practice within one particular SLT service will initially be explored using a form of action research called appreciative inquiry (this is described further below). The results obtained will then be integrated from those obtained from a UK-wide survey of SLTs working in adult services.

Why have I been asked to participate?

You have been invited to participate as you are a member of staff within the adult speech and language therapy service. You are therefore in a unique position as your contribution will help to shape our knowledge of how we enact and apply this concept in our everyday work with patients. Your influence and expertise will also contribute to the profession's understanding of the concept of person-centredness. Participation is completely voluntary.

What will happen if I take part?

By being a participant in this study you will be invited to attend an appreciative inquiry workshop. Appreciative inquiry is a form of action research where the emphasis is on exploration of what is currently working well and then using this to determine future practice. This is achieved through positive questioning and dialogue within a workshop format.

Each workshop is anticipated to last between 2-3 hours, and will follow a set format and flow. Prior to each workshop each clinical team will be asked to complete an online diary /journal, reflecting on person-centredness within that particular setting. Written guidelines will be provided by the researcher.

Each clinical team will be invited to participate in its own separate workshop and staff will be asked to;

- ‘interview’ each other (in pairs) and feedback to the rest of the team (guidelines will be given in the workshop)
- The team will then work as a group to highlight stories and extract common themes from the workshop and the journals
- The team will choose one story that best exemplifies the topic of ‘person-centredness’.
- The team will then project into the future and imagine what everyday practice would look like were it to be underpinned by the positive attributes uncovered in the workshop. The team will consider what practices to keep and which ones to change, and whether a project is required in order to bring about these changes.

After completion of each separate workshop, a representative from each group will be required to participate in another, final workshop, where the data from each separate clinical setting is brought together and overarching themes are analysed. In this way an action plan which is co-created by participants and researcher can be produced for the service.

The emphasis throughout is on co-creation of local knowledge which in turn can lead to opportunity for service transformation. This knowledge can then also be aligned and integrated with knowledge or data generated at a wider UK level which will be achieved through an online survey.

Will the data be confidential?

Part of the workshops (apart from the initial interviewing in pairs) will be audio recorded, with consent. The audio recordings will only be transcribed by the researcher. The transcripts will not contain your names and your participation will be confidential. Only the researcher will have access to the raw data. In accordance with Cardiff University and NHS guidance, the data will be kept for a minimum of 5 years, or at least 2 years post-publication. It will then be destroyed. The transcripts will be stored securely electronically in a password-protected file on the NHS IT system. The audio recordings will also be stored securely in a locked filing cabinet on NHS premises.

Confidentiality may however be broken if there is any evidence of malpractice or revelation of any practice that may impact on patient safety and quality of care or risks to staff. This would include any practice not adhering to the HCPC Code of Practice, the RCSLT's standards of practice or the Health Board's standards of values and behaviour. In this instance the researcher will be guided by local policies within the Health Board and advice from HR.

How will my personal data be managed?

Cardiff University is the sponsor for the study based in the UK. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Cardiff University will keep identifiable information about you for 5 years after the study is finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection or by contacting the University's Data Protection Officer: inforequest@cardiff.ac.uk.

Can I change my mind and withdraw from the project?

You may withdraw your participation from the project at any time and without any disadvantage. If you choose to withdraw after participation, you are also able to withdraw your data up to the point of anonymisation. The data will be anonymised immediately after each workshop, so that staff from different clinical settings will not be able to identify each other. Since the data from each separate workshop are produced collaboratively then the team members of each setting will be able to identify each other's data.

What use will be made of the collected data?

The data will be used to write a report, which will form the basis of a service improvement programme for the service. This report will be shared with the staff and other stakeholders within the organisation and may also be shared across the SLT profession via professional publications, academic journals and presentations. The data will also be used for educational purposes as they will form part of a doctoral thesis for submission to Cardiff University. No one will be able to identify you from the published results.

Are there any advantages or disadvantages to participating in the study?

The advantages of taking part are a contribution to greater understanding of person-centred care within our service and the SLT profession as a whole. This should ultimately enable the service to develop and improve what is offered to patients. The main disadvantage to taking part may be the time involved.

Who is organising the study?

This study is conducted by Nia Came (CameNF@cardiff.ac.uk) and supervised by Dr Sara MacBride-Stewart (Macbride-StewartS@cardiff.ac.uk), School of Social Sciences, Cardiff University, and Dr Katie Webb (WebbKL1@cardiff.ac.uk), School of Medicine, Cardiff University.

Who has reviewed the study?

This study has been reviewed and approved by the Cardiff University Research Governance Team and the School of Social Sciences Research Ethics Committee. It has also received approval from Health and Care Research Wales and Cardiff and Vale University Health Board.

What if I have any questions?

There will be an opportunity to raise questions in the project briefing meeting, or alternatively you may contact Nia Came or either of her supervisors at Cardiff University at the emails given previously. There will also be an opportunity to raise any concerns or questions at the end of each workshop.

What if there is a problem?

If you have any concerns or wish to complain, please contact Nia Came (CameNF@cardiff.ac.uk) in the first instance. If your concern is not allayed then please contact Dr Sara MacBride-Stewart (Macbride-StewartS@cardiff.ac.uk), School of Social Sciences, Cardiff University, or Dr Katie Webb (WebbKL1@cardiff.ac.uk), School of Medicine, Cardiff University. Should you have further concerns then please direct these to the Ethics Committee, School of Social Sciences, Cardiff University (socsi-ethics@cardiff.ac.uk).

If you are upset or distressed by any aspect of this research please contact:

Employee and Wellbeing Service, Cardiff & Vale University Health Board.

Telephone 029 2074 4465 o

Email: employee.wellbeing@wales.nhs.uk

Appendix 4 – Consent Form

Exploring speech and language therapists' (SLTs') understanding of person-centred practice using appreciative inquiry.

Consent Form

I have read the Participant Information Sheet (version 2.2, 21/11/20) concerning this project and understand what it is about. Any questions I had have been answered to my satisfaction. I understand that I am free to request further information at any stage. I know that:

Please initial

1. My participation in the project is entirely voluntary. ☐

2. I am free to withdraw from the project at any time without any disadvantage. ☐

3. If an audio recording is made, it will be kept in accordance with research governance policies and any raw data on which the results of the project depend will be retained in secure storage in accordance with Cardiff University and NHS data protection regulations. Workshop recordings will only be transcribed by the researcher and only the researcher will have access to the raw data. ☐

4. I have the right to decline to answer particular question(s). ☐

☐

5. I understand that I am free to withdraw my data up to the point of anonymization.

6. The results of the project may be published and used for educational purposes but my anonymity will be preserved. ☐

7. I agree to take part in this study. ☐

Participant

Name: ___________________________ Signed: ___________________________ Date: ___________

Researcher

Name: ____________________________ Signed: __________________________ Date: ___________

Thank you.

Contact details

Nia Came CameNF@cardiff.ac.uk Tel:

Consent Form Version 2.0 April 2020
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Apppendix 5 – Online Survey

Exploring speech and language therapists' understanding of person-centred practice

Page 1: Participant Information

I would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully and discuss it with others if you wish.

Contact me by email on CameNF@cardiff.ac.uk if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This project explores speech and language therapists' understanding of person-centred care (PCC). It also explores how this is enacted or carried out in daily practice. This survey is part of a larger study. The results of this study will be integrated with an indepth study in one institution.

The involvement of patients and their families as equal partners in decisions about their own care is felt to be important in the area of rehabilitation. This is particularly important when working with individuals with communication and swallowing disability. While person-centred care is 'best practice' and a sign of a quality service, this project explores what happens in practice. To do this I will ask you about your understanding and use of person-centredness in your practice and approach. These issues could be more relevant now due to the Covid-19 pandemic, which has resulted in changes in working practice.

This study uses appreciative inquiry.

This is a form of action research which focuses on what is working well to determine future practice. It will be used to contribute to the SLT professional literature on understanding person-centred care.

Why have I been invited?

You have been invited to participate because:

1. You are a qualified SLT
2. You work in a service for adults (excluding Learning Disability) in the UK.
3. You have a minimum of 6 months' experience working in the UK.

I am seeking a diversity of SLTs working across clinical caseloads and settings eg acute / in-patient rehab / community etc. If 1, 2 and 3 above DO NOT all apply to you, please exit the survey now.

Do I have to take part?

Participation in this survey is voluntary. You can withdraw at any stage by closing the questionnaire without being penalised or disadvantaged in any way. You can withdraw at any stage after submission by contacting the researcher.

The survey is anonymous and you will not be asked for data that could identify you personally.

Consent is indicated by clicking on the 'submit' button.

What will happen if I take part?

In order to reach as many SLTs as possible across the UK, an online survey is being used. This survey will be available for 4 2 / 14 months from March to June 2021. It only needs to be completed once. It should not take more than 30 minutes of your time. The survey comprises a mix of tick-box answers, ranking answers and free text boxes. It requires you to reflect on person-centred practice and asks about clinical vignettes based on your experiences.

What does taking part entail?

The survey asks for background details about yourself, such as years post qualification and clinical setting. It explores how you work with clients or patients and asks for your thoughts and understanding of person-centred practice. The survey concludes by asking you about your opinion of person-centred practice in reality.

Are there any disadvantages of taking part?

The survey should take 20-30 minutes. Aside from the time taken to complete the survey, no other disadvantages are foreseen in taking part in this survey.

Are there any benefits?

By taking part you will contribute to the profession's conceptual understanding of person-centredness. The survey may also indicate whether this varies according to clinical setting. This project should also clarify barriers and facilitators to practising in a person-centred way. It is anticipated that the knowledge gained will aid SLTs in developing services that are truly person-centred.

When will the study finish? The survey will be open to participants for 4 months between March and June 2021. During this time data will be analysed on an ongoing basis and will be stored securely at the researcher's NHS department according to NHS and Cardiff University GDPR regulations.

Is participation confidential? Only anonymised data will be collected therefore your participation is confidential.

Will the results of the survey be published?

The survey results will form part of a thesis submission for a Professional Doctorate in Health Studies, Cardiff University School of Social Sciences. The data may also be published within other SLT professional and / or academic journals.

What if I have any concerns?

Initial concerns should be directed to the researcher at CameNF@cardiff.ac.uk. Should you have further concerns that cannot be dealt with at this stage, then they can be directed to the Professional Doctorate supervisors at Cardiff University. These are Dr. Sara MacBride-Stewart (MacBride-StewartS@cardiff.ac.uk) and Dr. Katie Webb (WebbKL1@cardiff.ac.uk).
Further formal concerns can be directed to Cardiff University's Research Governance department:

Research Governance Department, Research and Innovation Services, Cardiff University, 7th Floor, McKenzie House, 30-36 Newport Road, Cardiff, CF24 ODE Tel: 02920879277

Consent to participate

By clicking on the start button you confirm you:

Are a qualified SLT registered with HCPC

Agree to take part in the survey

Have read and understand the information provided above

Understand that participation of the survey is voluntary
Understand you are free to withdraw at any time without giving any reason (by exiting the survey)

If you have 20-30 minutes now to complete the survey, click NEXT. Thank you for reading this information sheet and participating in the study.

Page 2: Exploring speech and language therapists' (SLTs') understanding of person-centred practice.

Section 1 - About You

The following sections ask for patient stories and clinical experiences. Please do NOT include any patient-identifiable information. It should not take more than 30 minutes to complete. There are four sections to complete.

1. I work in the:

- NHS
- Non-NHS
- Both

2. My clinical setting is (please tick all that apply):

Acute Inpatient rehabilitation
Outpatient rehabilitation
Early supported discharge
Community
Nursing homes
Private practice
University
Other

2.a. If you selected 'other' please specify below:

3. Years of clinical experience:

1 year, I am a new graduate
2-5 years
6-10 years
11-15 years
16-20 years
Over 20 years

4. My highest level of academic achievement is:

Bachelor

PGCert/PGDip
Masters
PhD/Prof Doc
Other

If you selected Other, please specify:

5. I currently work in:

Wales
Scotland
England
Northern Ireland
More than one

6. Please confirm you have been practising in the UK for 6 months or more:

Yes
No

7. My age range is:

20-30 years
31-40 years
41-50 years
51-60 years
61-64 years
65+ years

8. I am:

Female
Male
Non-binary

Section 2 - Explores more about you as a professional and the values and practices that are key to how you work with patients.

Please reflect on the values that underpin your clinical practice before responding to the questions below

9. In your opinion, do you think person-centred care happens in SLT? Pre Covid?

Never Sometimes Always

9.a. Please expand

10. In your opinion, do you think person-centred care happens in SLT? During Covid?

Never Sometimes Always

10.a. Please expand.

11. Can you describe what person-centred care looks like and how it informs your SLT practice?

12. Can you describe the key values of person-centred care that inform your SLT practice?

13. Please rate the following factors according to priority in clinical practice (on a 10-point scale, where 1=not at all important and 10=very important).

Please don't select more than 1 answer(s) per row.

Person/patient's wishes
Evidence-based practice
Acknowledgement of person's perspective
Relationship between health professional and service user
Shared decision-making
Provision of information
Clinical setting
Local context
Service resources/capacity
Funding
Other

13.a. If you checked 'other' please specify below:

14. How has Covid affected person-centred care in SLT?

Section 3 - Research suggests person-centred care in practice may differ from the principles. This section asks about examples of person-centred care within your SLT practice.

15. Please tell a story about the most recent experience in your career which made you feel that you were working in a person-centred way. Describe the situation. Please give as much detail as possible including where it happened, who was involved and your reflection on the situation.

16. What was important about your SLT role in this situation? How did it make you feel?

17. Were other professionals involved? Did they approach person-centred care in the same way or differently? What did you notice about their approach?

Section 4 - The next section consists of rapid answer questions concerning the feasibility of person-centredness in the clinical setting.

18. Are there any other issues which affect your ability to be a person-centred practitioner? (please tick all that apply):

Clinical experience
Confidence
Team or workplace culture
Service constraints
Funding
Training
Digital / technology
Leadership/Governance
Covid-19
Other

18.a. If you selected Other, please specify:

19. Do you think that there is any tension between person-centred care and evidence-based practice?

No Yes

19.a. If you selected Yes, please specify:

20. What are the facilitators and/or barriers to providing or enacting person-centredness in your particular clinical setting? Pre and during Covid?

20 a) Facilitators?

20 b) Barriers?

21. Finally, is there anything else you would like to add about person-centred care not covered by this survey?

Appendix 6 – Appreciative Inquiry Workshop Questions

1.**Discover**

Tell your partner about a time(s) when all the pieces fell into place and you and your team were able to deliver person-centred care to a patient/service user.

What made this patient story good?
What do you value in person-centred practice?
What is working well currently and what are the opportunities for change?

2.**Envision**

What do we want more of?

3.**Co-create**

Exceptional patient care is a complex process. Imagine you have a magic wand and can give every patient an exceptional experience with you.

How would our service look if ‘peak experiences’ were a regular occurrence?
How would your practice be different?
What possibilities do you see for this way of working?
What would your patients / families be saying about you?
What would your teamwork be like?

4. **Embed**

What actions are needed to enable and sustain change?