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The Experience of Providing Physical Therapy in a Changing Health Care Environment

Background and Purpose. The changes in the health care environment during the last decade have had an impact on the roles and responsibilities of all health care professionals. The purpose of this phenomenological study was to describe the experience of staff physical therapists during a time of systemic change within a large urban academic medical center. Subjects and Methods. Participants were 5 physical therapists working in various clinical settings within the medical center. The participants were interviewed and asked the question “Over the past 4 years, there have been major changes in your work environment. What has it been like for you working as a clinician during this time of change?” Interviews were recorded, transcribed, and analyzed to find thematic patterns of responses. Results. Four common themes emerged in which participants described experiencing loss of control, stress, discontent, and disheartenment. A fifth theme showed that despite these negative feelings, participants were able to “find the silver lining” in their daily work lives (ie, they were able to find positive aspects of their professional lives despite the perceived unpleasant changes with which they had to cope). Discussion and Conclusion. This study provides insight into the experiences of a group of staff physical therapists during a time of systemic change in their work environment. Although the themes reflect largely unsettling and negative experiences, there seems to be an underlying ability to find affirmative aspects of work. [Blau R, Bolus S, Carolan T, et al. The experience of providing physical therapy in a changing health care environment. Phys Ther. 2002;82:648–657.]

Key Words: Health care environment; Merger; Physical therapy profession, professional issues.

Rosemary Blau, Sarah Bolus, Terrence Carolan, Daniel Kramer, Elizabeth Mahoney, Diane U Jette, Judy A Beal
Changes in the health care culture have had an impact on all health care professionals, with new models for patient care, management organization, cost containment, and productivity measurement emerging.¹⁻⁴ These changes, including computer-based charting, downsizing or merging of departments, and adjustments of managerial staff, have led to a redesigning of the roles and responsibilities of physical therapists within many clinical settings.⁵⁻⁷ Few studies have investigated the effects of the changing health care culture on the experiences of physical therapists. Two studies by Lopopolo⁵⁻⁸ investigated the manager’s perception of the effects of hospital restructuring on the roles of physical therapists in the acute care hospital setting. She found that nearly 50% of respondents in her survey felt that hospital restructuring had moderate to significant effects on the delivery of physical therapy.⁸ She also found that changes in the role of physical therapists occurred primarily in the areas of patient care delivery and professional interaction.⁹ Lopopolo’s research was limited by the fact that the staff physical therapists involved in direct patient care were not included as participants.

Broom and Williams⁹ investigated issues of occupational stress after hospital restructuring in physical therapists working in neurological rehabilitation. They found that stress affected therapists both personally and professionally. They identified increased clinical workload and paperwork, desires to live up to professional role expectations, and diminishing resources as sources of stress. In this study, the authors focused on the stress experienced by physical therapists after hospital restructuring and not their overall experience of hospital restructuring.

Deckard and Present¹⁰ examined the relationship between role stress and well-being of physical therapists.

R Blau, PT, MS(PT), is Staff Physical Therapist, Brigham and Women’s Hospital, Boston, Mass.

S Bolus, PT, MS(PT), is Research Assistant, Beth Israel Deaconess Medical Center, Boston, Mass.

T Carolan, PT, MS(PT), is Staff Physical Therapist, Kessler Institute for Rehabilitation, West Orange, NJ.

D Kramer, PT, MS(PT), is Staff Physical Therapist, New England Rehabilitation Hospital, Woburn, Mass.

E Mahoney, PT, MS(PT), is Staff Physical Therapist, Boston Medical Center, Boston, Mass.

DU Jette, PT, DSc, is Professor and Program Director, Program in Physical Therapy, Graduate School for Health Studies, 300 The Fenway, Simmons College, Boston, MA 02115 (diane.jette@simmons.edu). Address all correspondence to Dr Jette.

JA Beal, DNSc RN, PNP, is Professor and Associate Dean for Nursing, Graduate School for Health Studies, Simmons College.

At the time of this study, Ms Blau, Ms Bolus, Mr Carolan, Mr Kramer, and Ms Mahoney were students in the Program in Physical Therapy, Graduate School for Health Studies, Simmons College. This study was completed in partial fulfillment of the requirements for their Master of Science in Physical Therapy degree.

All authors provided concept/research design and writing. Ms Blau, Ms Bolus, Mr Carolan, Mr Kramer, and Ms Mahoney provided data collection/analysis and project management. Dr Jette and Dr Beal also provided data analysis.

This study was approved by the Institutional Review Board of Simmons College.

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They defined role stress as a struggle between organizational responsibilities and physical therapists’ perceived professional responsibilities. Their study associated role stress with decreases in both the physical and emotional well-being of physical therapists. Deckard and Present, however, did not investigate the effects of hospital restructuring on the therapists’ well-being.

Given that researchers have not examined the overall experience of hospital restructuring and systemic organizational change from a staff physical therapist perspective, the purpose of our study was to describe the experience of staff physical therapists who provided patient care during a period of systemic change in a large urban academic medical center.

**Methods**

**Design**

A lack of literature exploring the experience of change from the perspective of the staff physical therapist who provides direct patient care led us to use a phenomenological research design. In line with this research approach, once a gap in literature was identified, further review of the literature prior to initiation of the study was suspended to limit researcher bias. Phenomenological research was used in an attempt to identify and describe the elements of the experience from the perspective of the staff physical therapist.

Phenomenological research is supposed to aim at gaining a deeper understanding of the nature of everyday experiences. Phenomenology, according to its advocates, is designed to describe and interpret these experiences with depth and richness. Derived from the Greek word *phenomenon*, meaning, “to show itself,” phenomenology is supposed to be used to illuminate the true meaning of human experience through reflection by the participant and researcher. By taking the time to reflect on and record a given experience, both the participants and the researchers, in theory, can begin to share and understand the true meaning of everyday events or situations. This research method is based on the concept that there are essential structures to any human experience and that these structures have a pattern that is unique to each experience.

Max van Manen developed a phenomenological philosophy that incorporates aspects of both Husserlian and Heideggerian philosophy. Husserl used descriptive analysis that was void of interpretation by the researcher. Heidegger, however, allowed for some interpretation of the data by the researcher as a way to organize or present the information collected. In van Manen’s approach, understanding the meaning of a particular experience remains the researcher’s goal. His method allows for some interpretation of the data based on the researcher’s experiences and beliefs. Van Manen’s approach, however, also requires bracketing before and during the research process to limit bias. Bracketing is defined as the act of reflection by the researcher on any preconceived beliefs or feelings pertaining to the research topic. The investigator consciously sets aside, or brackets, these beliefs so that data collection and analysis may be approached from a nonjudgmental state. Specifically, van Manen’s phenomenological approach involves the following steps: (1) investigating an issue that merits attention based on its relevance to the members of a particular community, (2) investigating the experience by asking participants to describe and express thoughts and feelings that occurred during a specific time period, (3) extracting and reflecting on essential themes that characterize the phenomenon, (4) describing the phenomenon through writing and rewriting in order to refine and clarify the common themes, and (5) utilizing the researchers’ personal experiences in order to interpret these themes.

**Subjects**

Participants for our study were selected from an employee roster of the rehabilitation services department at a large, urban, academic medical center in the northeastern United States. The institution was selected because there had been many major organizational changes within the rehabilitation services department as well as throughout the institution over a 4-year period. Institutional changes included merging 2 hospitals with different cultures and structures into one. The rehabilitation departments of the 2 institutions were merged under the management of one director. Administrative changes within the rehabilitation services department included decreased number of support staff, increased requirements for documentation, increased productivity expectations, a new computerized documentation system, patient scheduling changes, and changes in how time could be billed.

Purposeful selection from the employee roster was used to ensure representation from all clinical settings within the hospital. All physical therapists recruited spent at least 80% of their time directly involved in patient care and were employed at the institution for at least 4 years prior to 1999. Two of the therapists saw patients in the outpatient department, one therapist saw patients in the inpatient department, one therapist saw patients in home care, and one therapist saw patients in an off-site outpatient satellite clinic. The study participants were 5 female physical therapists ranging in age from 27 to 48 years. Their years of experience practicing as clinicians ranged from 4 to 20 years. The years practicing as this specific institution ranged from 4 to 20 years, with 2 clinicians having worked only at this institution.
The sample size was determined by thematic saturation. Thematic saturation occurs when the researchers determine that themes suggested by participant interviews begin to repeat themselves and subsequent participants’ interviews yield no new themes. In this study, thematic saturation occurred, in our opinion, with a sample of 5 participants.

**Procedure**

A recruitment letter was sent to each potential participant. The letter included a brief description of the study and the research question. Once participation was agreed upon and informed consent was obtained, an interview of approximately 1 hour was conducted at a site away from the workplace. Of the 15 employees identified as possible participants, 7 agreed to participate and 5 were interviewed. The same researcher (TC) conducted all interviews.

The initial interview was conducted during the fall of 1999. The interview was driven by one main question: “Over the past 4 years, there have been major changes in your work environment. What has it been like for you working as a clinician during this time of change?” Additional questions were asked during the initial interview to clarify the thoughts and feelings presented by the participants. Examples included: “Can you elaborate on that?” and “How did that make you feel?” The interviews were audiotaped and professionally transcribed to ensure accuracy.

**Data Analysis**

We analyzed the transcripts of each participant’s experiences, using van Manen’s method, through reading, discussing, and rereading the participants’ responses to extract and reflect on essential themes. Reflection and discussion among all members of the research team continued until several essential themes emerged that seemed to characterize the phenomenon of providing physical therapy in a changing health care environment. This process took 4 months. Themes were described through a combination of the participants’ words and the personal experiences of the investigators. Once the themes were extracted from the transcripts, a written summary of the themes was mailed to the participants, and a second interview was conducted by telephone during the spring of 2000. During this second interview, the themes were presented to the participants for validation. Additional comments were welcomed.

**Methodological Rigor in Qualitative Research**

Methodological rigor refers to the reliability and validity of the results produced by the qualitative process. Methodological rigor is attained by ensuring that the amount of data collected is sufficient for thematic saturation and that the themes are fully accounted for, understood by, and agreed on by the researchers. An audit trail is another way to ensure methodological rigor, and this was conducted throughout our data analysis. The audit trail is the careful documentation of how the researchers conceptualized and categorized the data collected. The importance of an audit trail lies in the ability of the interested parties to reconstruct the process by which the researchers arrived at their conclusions. We used several documentation methods for the audit trail: transcribed interviews, follow-up interviews, use of process notes, data reconstruction to synthesize notes, and use of materials relating to the dispositions of the researchers.

We also attempted to ensure rigor through bracketing, the second participant interview, and review by experts in phenomenology. The bracketing process began as the project was formulated. Each researcher wrote down all potential biases he or she held regarding the phenomenon being investigated. A written log of any new bias that were identified during the research process also was maintained by each investigator, and this information was shared with the other investigators. During data analysis, we referred back to these written logs in an effort to ensure that any potential biases were not influencing the extraction of essential themes. The second interview allowed the participants to verify the themes that emerged from the text and to articulate any new themes not represented. Two of the investigators, one with advanced training in the phenomenological method and the other a physical therapist researcher on a faculty, also participated in an effort to enhance the rigor of the research. Each of these individuals reviewed the research question, the method, and resultant themes. Finally, the transcripts, themes, and interpretations were reviewed and confirmed by an expert phenomenological researcher who had not been involved in the project.

**Results**

Four common themes emerged that suggested the physical therapists’ experiences could be characterized by loss of control, stress, disheartenment, and discontentment. A fifth commonly found theme showed that despite the negative feelings, the physical therapists in our study were able to “find the silver lining” (ie, the positive aspects of their professional lives despite the unpleasant changes with which they had to cope).

**Loss of Control**

The physical therapists described a sense of having lost control of their work environment, which as a result affected both their professional and personal lives. There was an increase in the number of work responsibilities and a change in expectations for the number of
patients admitted and treated every day. Participant 5 discussed the chaos of the work environment:

I have a constant number of new patients that roll onto my schedule every week whether or not I’m done with the patients that I had weeks ago. . . . That constant, air traffic controlling-type feeling can make every minute count at work and can be stressful just to try to handle the volume of patients coming through.

The therapists felt they had less control in deciding how patients were treated. They found that they were spending less time with patients, and they questioned their ability to provide the level of care that they felt was most beneficial. Participant 3 made the following statement:

I think one of the other things is you feel as if you [have] less control as a clinician in deciding what happens with your patients. . . . Everything is based on how often you can see this patient and how much time you can spend with them. . . . Sometimes, patients come in, and you feel you could spend an hour with them, but you’re not encouraged that way.

Therapists were also asked to work with constantly changing expectations and were required to adapt to new policies implemented by the institution. At times when the therapists felt they had adequate resolution and control of the environment, another change was mandated and control once again was lost. Personal coping skills were challenged in this ever-changing work environment. Participant 5 summarized:

I have found I’ve gotten to a point where I’ve just nearly had a meltdown at work. . . . I don’t know how I can handle all that’s supposed to come in, and we keep getting told we’re supposed to figure out a different way of handling things, but that’s not all that easy to do.

Participant 4 stated her feelings of loss of control in a similar manner:

[There are] days when you’re seeing so many people that you’re going crazy, and it doesn’t get better and better, it only gets worse and worse, and you feel like you’re mentally going crazy and going nuts and you’re going to . . . crack . . .

Loss of control also resulted from therapists working greater than an 8-hour day, working weekends, and giving up part of their personal lives and professional growth to compensate for demands of the work environment. As participant 1 stated:

You get here, you need to be dressed and ready to go at 8:00 AM, and you’re going, going, going until 6:00 or 6:30 every single night. So I mean work, work, work is all you’re doing. You’re not getting a lot of personal time. You’re not even getting any time during your own day to do educational things for yourself like having meetings with your team leader or someone that’s an expert or has a specialty area that you might be interested in.

Our participants felt they had lost the ability to influence the environment in which they worked. Expectations of a high level of adaptability, increased workload, decreased control of work outcomes, and decreased opportunity for professional development were identified as factors that contributed to feeling loss of control. A perception of increased workload is consistent with Lopopolo’s findings. In a survey of clinical managers in settings where restructuring had occurred, the majority of the respondents in Lopopolo’s study stated that focus on productivity had increased. In an earlier study, Lopopolo found that physical therapists were expected to be more flexible in carrying out work assignments.

Cangelosi et al., in a survey study of nursing retention and recruitment, found that when a job allowed employees to feel personally responsible for a large segment of their work outcomes, they perceived their work as meaningful. One might surmise that a lack of control would lead to a decreased sense of responsibility and lower valuing of work. Jensen et al. found that one common feature of expert practice in physical therapy was the professional role of patient advocacy, which was attained through persistent correspondence with other health care professionals, letters, and documentation. This behavior is likely to result in the fulfillment of the physical therapists’ professional expectations for responsibility of patient care and outcomes. We believe it is precisely this type of behavior that may be jeopardized by the time constraints, external demands, and loss of control reported by our participants.

Stress
The source of the therapists’ stress seemed to originate from the increasing number of patients, lack of support staff, and documentation demands. The stress seemed to result in both professional and personal doubts about their futures as physical therapists. Participant 4 shared:

I mean I’m stressed. I’m thinking about moving on and thinking I can’t do this forever. I’m going to get burnout. . . . I come here sometimes, and I’m just. . . . so stressed it’s [time to] break down and cry. . . . and I’m usually a strong person.

Stress appeared to be related to time, as the therapists felt there was never enough time to accomplish the tasks required. The level of stress seemed to be affected by a combination of factors that challenged the ability of the therapists to cope. One factor was the coupling of increased patient load with decreased time available for
examination and treatment of each patient. This combination led to an overwhelming feeling of busyness and a burdensome feeling of never reaching work-related goals. As participant 5 stated:

You know, I don’t end up with a lot of time, and I can feel the tension with knowing I want to run on time, but I have to get this data [from the patient] because I have to make a real good argument to the insurance company. It’s pretty stressful, and sometimes I just choose to run over.

At times, both professional and personal goals were not met. Participant 5 described:

I wasn’t meeting goals at work, I wasn’t meeting goals at home, and I wasn’t meeting goals for me.

Another component of feeling stressed was the lack of support staff in the physical therapy department. Therapists found themselves performing many duties that previously might have been delegated to a physical therapy aide. These tasks included setting up treatment rooms, getting patients ready for treatment, and replenishing supplies. Participant 2 explained:

[It would help to have] aides to clean up after you. Have somebody bring your patient in, have your patient changed and ready for you to start interviewing them and go straight into the examination, have the vital signs checked out from your patient. So everything’s done so that when you’re ready for your patient, you go straight in and you can do everything that’s expected of you within the time frame allotted to you.

Documentation demands were also a source of stress. In the past, therapists believed they were able to complete documentation within the 8-hour workday because it was included in the time that they were scheduled to spend with their patients. At the time of the interviews, documentation time was excluded from the allotted treatment time. This resulted in many cases of encroachment on the therapists’ personal time, with therapists doing paperwork outside of the workday. Participant 5 stated:

There’s lots of tension, trying to run on time, trying to give the patients the best care, and try[ing] to do everything that I need to do to give them that care. I’ve already made the decision that it’s not going to get written up until later, which is it’s own stressor, but just trying to even sit down can be pretty hard. I can’t even go to the bathroom when the day gets that backed up. Lunch—I’ve never eaten lunch away from my desk. I’m doing documentation at lunchtime . . .

The lack of time in the day to address their own emotional and psychosocial well-being was another source of stress. As participant 1 remarked:

You know, I don’t end up with a lot of time, and I can feel the tension with knowing I want to run on time, but I have to get this data [from the patient] because I have to make a real good argument to the insurance company. It’s pretty stressful, and sometimes I just choose to run over.

Our participants identified sources of stress that included increases in workload, increases in the amount of documentation, decreases in support staff, and increases in time demands at work. Concurrently, our participants reported reductions in time for patient care due, in part, to increases in responsibility for tasks traditionally accomplished by support staff. Our participants noted these changes as sources of stress.

Geddes et al. investigated the work lives of nursing administrators working in a hospital setting. They found that changes in the documentation system required more processing time and created an information overload. Thus, the changes created constraints on time and increased the difficulty of information management. These changes and constraints were similar to those described as contributing to stress in our participants. Our findings are similar to those reported by Broom and Williams. They found that work overload was attributed to a combination of understaffing, huge patient numbers, and extra administrative responsibilities. The work overload identified by Broom and Williams and reported by our participants seems likely to contribute to an increased level of stress.

Disheartenment

The third theme described the therapists in our study as feeling disheartened. Disheartened is defined as “a state of having depressed hope, courage, or spirits.” The participants expressed a sense of hopelessness about their work environment and its effect on patients. At the core of feeling disheartened was a feeling of sadness at the present set of circumstances. Our participants felt upset when they could not provide adequate patient care. Participant 1 stated:

You can’t see 18 patients in a day. . . . That’s really hard, and if you know that they need therapy, yet you can’t give them what they need, you feel bad, you feel like here they are . . . they really need therapy and we’re not able to give it to them. Or we’re able to do a 15-minute treatment, and is that really doing anything for them?

The participants also felt that tensions in their relationships with their peers surfaced because of the increased demands in the workplace. This strain on collegiality seemed to contribute to feeling disheartened and distant from the supportive network of coworkers. As participant 2 shared:
You have people you work with who snap at you and then don’t say, “Well, I’m sorry. I really didn’t mean it.” And then, it then leads to strain in your relationship with your peers, which, again, is not conducive to a happy work environment. It was just closer [before]. I guess you could talk more easily to your colleagues, and then you didn’t expect somebody to turn and snap at you. But also it was a smaller department, and smaller departments are more conducive to one-on-one relationships rather than a bigger place.

Another contributor to feeling disheartened was the lack of resources available for professional development. The loss of institutional financial support and time for education, and resignations of experienced clinicians affected the therapists’ ability to invest in their own professional growth. Participant 4 expressed:

I think when I first started working, I was lucky in that there was a bigger commitment [to] teaching and teaching the new therapists, and there was a huge amount of resources. . . . And there are still resources, but a lot of them have left. We had more opportunities to go to specific courses for continuing education, whereas that’s not really an option right now . . .

Participant 5 offered:

It’s very upsetting, because I’m not investing back in myself, in what I do. And when you ask yourself the same clinical question over and over again, [I think to myself] “I really should look up such and such”; a week later, “I really should look that up.” And it would take a few minutes, but sometimes I don’t even have a few minutes to look it up.

Emotional struggle in balancing personal lives with patient needs was a source of disheartenment. Their reasons for entering the field of physical therapy were challenged by this struggle. Participant 4 communicated:

You . . . came in to help people, but . . . I mean, I’m kind of just doing what I have to do and trying my best to stay with it, but I can’t . . . it’s not that I can just be like, “Okay, well, . . . I’m just not going to see anyone else this day” or “I’m going to leave at 4:30 and be done with it,” because I would feel bad, feel guilty that I have all these other patients that might not get seen.

This participant continued:

I don’t feel as upbeat as I was 4 years ago. [I] feel kind of down.

The theme of feeling of disheartened in our participants seemed to be related to factors such as an inability to spend the desired amount of time on patient care, overwhelming work responsibilities, a decrease in collegiality, and detachment from a support network. Similarly, the managers surveyed by Lopopolo16 felt that time spent by physical therapists in patient care had decreased with hospital restructuring. Broom and Williams9 noted that physical therapists expressed feelings of personal disappointment with their inability to meet perceived personal expectations. Our participants described similar feelings of disappointment when they were unable to give the type of treatments they wanted to the large number of patients on their schedule every day.

Discontent

Discontent, including feelings of resentment, frustration, and exasperation, also was present, and it was combined with a longing for the better times of the past. The participants recalled “the good old days” when they felt their work environment was somehow better or more desirable. There was a longing for this prior time and the better conditions that seemed to exist.

One aspect of discontent was frustration with the percentage of time spent treating patients compared with the percentage of time spent performing administrative duties. There was a feeling that in the past documentation constituted a much smaller percentage of the total workday. This proportionately smaller amount of time spent directly with patients was viewed negatively. When asked if she could compare the way that she practiced 4 years ago with the way that she practiced today, participant 2 replied:

Less time spent directly with patients and more time spent doing administrative-type things.

She went on to say that the current circumstances made her feel:

. . . frustrated at times. When you feel that the patient isn’t getting better. I mean, at times, there are patients getting better, and it’s fine. You accept the changes for what they are. But at other times, you think back on the good old days and you had the ability to do a lot of things.

The therapists felt they were not able to practice as they had 4 years ago due to an increase in the amount of documentation. This change was met with frustration and dissatisfaction because it was viewed as an obstacle to providing high-quality care to patients. The accompanying belief that colleagues employed at other facilities had less documentation demands added to this feeling of frustration. Participant 2 expressed:

It’s the paperwork that is expected of you after seeing people. And there are many other clinics where the paperwork is probably half or less than half of what we’re expected to do, especially on the initial encounter.
A second component of feeling discontented was a sense that the employer’s demands on each employee were above and beyond what was considered his or her professional responsibility. These demands often resulted in consistently longer workdays for which the therapist was not compensated. There was also a demand for frequent weekend shifts, which could occur consecutively for up to several weekends. As participant 1 stated:

I’m at work more than anywhere else and now I’m going to be at work more weekends. And, I mean, as it is right now, we’re working like almost every other weekend, which is a lot. . . . I mean, I feel like, you know, the hospital dictates my life as it is. You know, I feel like they expect us to work . . . a 10-hour day. I mean, we get paid for [working] 8 [hours], but I don’t remember the last time I left work before 6:00 [pm], and theoretically it’s, well, it’s our professional responsibility. And, you know, I understand professional responsibility to a point, but when you’re doing this every day, I think that’s above and beyond what’s professional.

Participants felt that the increasing demand on their time had a negative impact on their personal lives. Participant 5 felt resentful that practicing full-time was no longer an option for her because the impact on personal time was too high.

I resent that I can’t work full-time, because I think it’s almost impossible for someone to work full time . . . and have a life, and I’m not even asking for much of a life. I’m just asking for some life outside of work, and I resent that I have to accept less.

Finally, there was an aspect of feeling discontented that expressed a longing to return to a more desirable time of practicing physical therapy. This “desirable” time was seen as being less complicated or constrained by conditions in the work environment. The therapists felt that if they were able to reproduce those circumstances, the state of their practice would improve dramatically. Participant 4 stated:

It puts you feeling like you’re not necessarily giving all you can give or doing the best with the patients that you could, that a few years ago I could have done this or that, and now it’s not possible.

As participant 5 expressed:

I just wish it were possible for me to do my work as well as I think I’ve learned to do my work and not be so burned out at the end of the day or end of the week or end of the month.

Our participants were frustrated because they could no longer practice as they did in the past, and they expressed their frustration and resentment in different ways. The participants’ descriptions of the work environment are similar to those reported by Lopopolo.16 In her study, managers reported that the focus on documentation and administrative responsibilities had increased since hospital restructuring. Her respondents also indicated that the increase in administrative responsibilities had had a negative effect on patient care delivery. Geddes et al19 found that an increase in workload and changes in documentation contributed to creating turbulence and uncertainty in the work environment. Lopopolo8 also reported that decreasing staff support in an acute care setting resulted in lowering the productivity of professional providers by overburdening them with clerical tasks. This decreased level of support reduced the professional’s time for patient care.

Discontent also seemed to be the result of the consistent impingement of work on personal time and the difficulty balancing work with personal life. These findings seem to be supported by the literature. Lopopolo’s16 respondents noted an increase in work on weekends after restructuring, as did the physical therapists in our study. Broom and Williams5 found that physical therapists carried stress from work into their home lives and that they had trouble “switching off” at home at the end of the day. Similarly, Cartwright and Cooper,21 investigating the psychological impact of merger and acquisition on building society managers, found that an increase in workload affected outside relationships. Many of their respondents stated that their spouses had to cope with their working longer hours.

Finding the “Silver Lining”

Despite feeling loss of control, stressed, disheartened, and discontented, the physical therapists in our study were able to focus on positive aspects of their work environment. “Every dark cloud has a silver lining” is a metaphor that describes how the therapists viewed their work situation. Positive factors influenced the physical therapists’ feelings despite the unpleasant changes with which they had to cope. The therapists enjoyed their profession. As participant 5 stated:

The thing that I have tried to keep in mind is that I truly love what I do. I cannot imagine doing something else.

Despite the tensions in collegial relationships attributed to high work demands and expressed by the participants as discontentment, relationships with peers were generally seen as positive aspects of their work environment. Having friends at work made a difference in deciding whether to stay in or to leave their jobs. Participant 4 expressed:

I feel crappy most of the time . . . it’s less and less fun, let’s put it that way. I mean, the only thing that saves me is [that] I love 90% of the people I work with, and they’re my best friends, and that’s what keeps me hanging on to this job.
A final factor that was important for these therapists was delivering high-quality care. Although they felt that maintaining their standards for delivery of care had become more difficult for them over the 4 years previous to our study, they felt that the quality of care they provided was high. As participant 4 stated:

The standards of care and the quality of care that we deliver are very good. I feel very strongly . . . that we do a great job.

Despite all of the changes that occurred, the clinicians we interviewed were able to identify positive aspects of their professional lives. The foundations of this positive experience were the enjoyment of being a physical therapist, being professional, having strong relationships with peers, and the belief that they were delivering high-quality care to their patients.

Jensen et al18 found that expert clinicians who were identified by their peers appeared to set high standards for themselves and demonstrated a strong commitment to do what was best for their patients. The managers in Lopopolo’s study believed that therapists maintained a professional approach to work in the face of systemic changes in their work environment.8 These findings are consistent with our participants’ beliefs that they provided high-quality care and their dedication to doing what was best for their patients.

In 1997, Lopopolo5 reported that interacting with peers increased in importance, especially in physical therapy departments that were decentralized within a hospital and there was less ability for staff to interact. In her study published in 2001, the majority of managers she surveyed noted that they believed that social interaction with physical therapists within work environment increased after restructuring.16 Similarly, Broom and Williams9 found that physical therapists reportedly were able to cope with stress when they sought support from colleagues and managers. In our study, there is a seeming contradiction among the themes related to peer relationships. We believe that the participants expressed that there was tension in relationships as therapists attempted to cope with the changes in their work environment on a daily basis. Overall, however, relationships remained strong and important among the participants.

The “silver lining” theme that emerged from our participants’ experiences is supported by the findings of a recent published study by Stiller.22 Stiller used a qualitative method to describe the development of a professional ethos of physical therapy, and she identified 4 enduring traits, one of which was a positive attitude. The positive attitude was noted to be present when the participants in her study spoke about people in the profession as well as when they described changes that had occurred in the profession over time.

The experiences related by our participants are limited to one institution that underwent systemic organizational changes, including institutional and departmental mergers. Our study is also limited by the fact that all participants interviewed were female. Research has shown that women place a greater emphasis on peer relationships as well as on balancing career and home responsibilities.23 The majority of physical therapists, however, are women.24 Furthermore, we did not collect data that could be used to identify and characterize whether the environmental changes described to us by the participants actually took place. Research is needed to determine whether the experiences of the physical therapists in the institution that we studied are similar to those of physical therapists in other settings. It might also be of interest to determine whether experiences differ by gender or years of experience as well.

**Conclusion**

In our study, 5 themes were found that describe the experience of systemic institutional change among a group of physical therapists: loss of control, stress, disheartenment, discontent, and finding the “silver lining.” Although the majority of feelings associated with change in this setting were negative, the physical therapists valued their profession and their colleagues and took pride in providing excellent patient care. The findings suggest that those involved in systemic change may do well to find ways to emphasize the components of their practice environment that bring joy and satisfaction.

**References**


