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Evidence and/or Experience-Based Knowledge in Lifestyle Treatment of Patients Diagnosed as Obese?

by **Karen Synne Groven** and **Kristin Heggen**

Abstract

Proceeding from a phenomenological perspective, this study investigates how physiotherapists' experience-based knowledge acquires significance in their encounters with patients diagnosed as obese. Presenting the thematic accounts of three physiotherapists, this paper illuminates how they make use of experiences from both their own life as well as experiences from learning and doing physiotherapy. This multifaceted experience-based knowledge is significant for making individual adjustments in a group-based programme. In line with these findings, the authors question whether the therapeutic method itself can be given such a prime position in defining best evidence in evidence-based practice. In concluding, they call for a re-consideration of the term evidence. More precisely, it is argued that what will be "effective" therapy for a person diagnosed as obese cannot be reduced to external evidence.

> Because research is one thing ... but retrieving experiences from my *experience box* – **that** has impacted my approach. ... When I started working with this, in the beginning, I was more like this: Now you have come to the right place. I was kind of like that. I felt the need to convince them that I know what I am doing.

This is Nora, a physiotherapist, working within the specialist health service in Norway in a clinic specializing in group-based interventions for helping patients diagnosed as obese to lose weight. As a sporty and fit physiotherapist, Nora started working in the clinic, eager to help her patients accomplish this. However, through encounters with various patients, she came increasingly to question weight loss as the ultimate goal for everybody in the group. Could it be that, through her efforts to help patients become more active, pushing their limits, she risked doing more harm than good? Could it be that patients' sense of failure intensified when pain and discomfort prevented them from keeping up with the rest of the group during intense interval training or long outdoor hikes? Grappling with such questions, Nora increasingly came to rely on her "experience box".

Nora's reference to an "experience box" as something different from research indicates that she has learned the value of relying on her own clinical experience as opposed to research when treating patients diagnosed as obese. This is interesting, given the emphasis on evidence-based practice (EBP) as a premise for physiotherapists' professional approach. Indeed, evidence-based practice is emphasized from the very start when students embark on their physiotherapy training, just as it is emphasized as paramount for physiotherapists as part of their professional development as clinicians (Dannapfel, Peolsson, & Nilsen, 2013). According to Sacket (1997), evidence-based practice (EBP) can be defined as:

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> The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients ... integrating clinical expertise with best available external clinical evidence from systematic research. (p. 3)

At first glance, this definition acknowledges the need to combine the use of experience-based and research-based knowledge in making clinical decisions in the best interests of each patient. In reality, however, a hierarchy of knowledge has come to dominate EBP – a hierarchy that privileges research-based knowledge stemming from randomized controlled trials (RCT) as opposed to experience-based knowledge (Wellard & Heggen, 2011). Indeed, proponents of such a hierarchy regard randomized controlled studies as in effect the gold standard in terms of what counts as best evidence (Dannapfel, Peolsson, & Nilsen, 2013; Engebretsen, Heggen, Wieringa, & Greenhalgh, 2016; Gibson & Martin, 2003). Thanks to a quantitative research design – in which participants are randomly assigned to either an experimental group or a control group – researchers can measure the effect of the intervention itself. In other words, by comparing pre-and post-test results of the two groups of participants, differences in "effect" can be ascribed to the intervention itself, rather than to the therapist or the patient (Ekeland, 2009; Standal, 2008, p. 203).

Originating from the field of medicine in the early 1990s, EBP increasingly came to be adopted by other health professions, including that of physiotherapy (Ekeland, 2009; Gibson & Martin, 2003; Sacket, 1997; Turner, 2001). Consequently, research-based knowledge stemming from randomized controlled trials increasingly came to shape clinical guidelines as well as debates concerning how to implement *effective* physiotherapy approaches in clinical practice. Proponents of EBP regard this pendulum shift away from clinical experience towards more emphasis on standardized procedures as paramount in legitimizing the physiotherapy profession, paving the way in terms of identifying and justifying *effective* interventions that will most benefit patients (Dannapfel, Peolsson, & Nilsen, 2013; Gibson & Martin, 2003; Turner, 2001). Such a stance makes sense, bearing in mind that, thanks to randomized controlled designs, physiotherapists increasingly have come to challenge established medical interventions as the most effective means of treating various conditions. For example, an increasing number of studies have demonstrated that exercise-interventions can be just as effective as, and sometimes even more effective than, surgery related to various chronic conditions, including knee problems, shoulder pain and low-back pain (Brox et al., 2003; Hides, Jull, & Richardson, 1999).[1] Such results have thereby arguably served to establish the effectiveness of specific *methods* in physiotherapy. In particular, the effectiveness of specific exercise interventions has been subjected to randomized controlled trials, paving the way for a more active approach to patients struggling with various lifestyle diseases as opposed to more traditional and passive approaches (Morris, Kitchin, & Clark, 2009; Weston, Wisløff, & Coombes, 2014).[2] A relevant example in respect of our study is found in the recommendations regarding conservative treatment for persons diagnosed as obese published by the Norwegian Institute of Public Health (2013).[3] In their emphasis on effect, and the kind of approach that is most effective in terms of weight loss, 12 randomized controlled studies are scrutinized. Based on their review of these studies, the Institute concludes that interventions combining dietary and exercise interventions are more effective than interventions focusing on either exercise or diet modifications. Thus, the Institute follows the standard of prioritizing scientific evidence as far as active approaches are concerned. Moreover, it grades effect, based on pre-defined standardized tests and on how participants score on these tests. Accordingly, we are left wondering how the therapist played a role in these standardized interventions; for example, how he or she approached patients. More specifically, we are left wondering whether – and, if so, how – the therapists managed, in a group-based programme, to adjust activities according to each patient's needs and preferences. In other words, randomized controlled effect studies emphasizing standardization cannot provide detailed insights into physiotherapists' individual approaches and adjustments as part of their own clinical experience within one and the same intervention.

In this study, a phenomenological approach will be adopted in exploring this matter further. Moving beyond quantitative approaches to measure effect, we will take as our starting point physiotherapists' own experiences. More precisely, we will explore how physiotherapists' *experience-based knowledge* acquires significance in their encounters with patients diagnosed as obese.

Theoretical Framework

In this study, we take a phenomenological approach to physiotherapists' experience-based knowledge, seeking to provide a descriptive account of physiotherapists' experiences as these are lived through in various settings and situations. In line with Merleau-Ponty's theories, we regard lived-through experiences as bodily,

[1] https://fysio.no/Hva-mener-NFF/Fag-helse-og-arbeidslivspolitikk/Fysioterapi-eller-operasjon-ved-knesmerter; http://fysioterapeuten.no/Aktuelt/Nyheter/Fysioterapi-bedre-enn-operasjon

[2] http://www.dagbladet.no/2012/01/26/tema/god_torsdag/trening/sykdom/behandlingsmetoder/19951400/

[3] http://www.kunnskapssenteret.no/publikasjoner/effekt-av-konservativ-behandling-for-pasienter-med-overvekt-og-fedme

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embodied, subject to ongoing change. Even though we cannot always verbalize our experiences, they are part of our bodily being-in-the world; part of who we are, and what make each of us unique as we endeavour to make *meaning* of various settings and situations:

> Because we are in the world, we are *condemned to meaning* … . (Merleau-Ponty, 1945/2002, p. xxii)

> Bodily experience forces us to acknowledge an imposition of meaning which is not a universal constituting consciousness, a meaning which clings to certain contents. (Merleau-Ponty, 1945/2002, p. 170)

Merleau-Ponty accordingly elaborates on the body as our primary means of experience. Through our body we perceive ourselves as well as our surroundings. Through our body we seek to make meaning of situations that involve other people, such as seeking to understand a person's gestures when words are not uttered explicitly:

> It is through my body that I understand other people, just as it is through my body that I perceive "things". The meaning of a gesture thus "understood" is not behind it, it is intermingled with the structure of the world outlined by the gesture, and which I take up on my own account. (Merleau-Ponty, 1945/2002, p. 216)

At other times, we seek to make meaning of situations involving other people through explicitly verbalizing our experiences. Being part of a common world, sharing the same language codes, terms and phrases can help us verbalize ideas and thoughts so that we can come to understand others as well as ourselves in new and unforeseen ways:

> There is, then, a taking up of others' thought through speech, a reflection in others, an ability to think *according to others* which enriches our own thoughts. (Merleau-Ponty, 1945/2002, p. 208)

Along the same lines, Merleau-Ponty elaborates on *consciousness* as embodied, and thus intimately intertwined with a person's experience-based knowledge (Merleau-Ponty, 1945/2002, pp. 18-36). It accordingly follows that one cannot reduce human consciousness to mental aspects located inside a person's brain; just as one cannot reduce the body to a material object subject to the will of the person. Taking an embodied approach to consciousness involves being sensitive to how our encounters with others acquire significance in terms of shaping our experiences. In this regard, Merleau-Ponty points to consciousness as "perceptual" and the body as a "knowledge-acquiring apparatus":

> As for consciousness, it has to be conceived, no longer as a constituting consciousness, and, as it were, a pure being-for-itself, but as a perceptual consciousness, as the subject of a pattern of behaviour, as being-in-the-world … for only thus can another appear at the top of his phenomenal body, and be endowed with a sort of "locality". Under these conditions the antinomies of objective thought vanish. Through phenomenological reflection I discover vision, not as "a thinking about seeing", to use Descartes' expression, but as a gaze at grips with a visible world, and that is why for me there can be another's gaze; that expressive instrument called a face can carry an existence, as my own existence is carried by my body, that knowledge-acquiring apparatus. (Merleau-Ponty, 1945/2002, p. 409)

These considerations concerning the body's relation to itself and others serve as a contextual framework for our study. In contrast to the hierarchy of evidence which has come to dominate the philosophy of EBP, in which the therapeutic method is regarded as paramount and thus also essential in terms of what constitutes the most effective outcome for groups of patients, a phenomenological perspective calls for a both broader and more inductive focus, exploring how the therapist herself as well as her patient acquires significance in relation to how a particular intervention or therapeutic method is organized, experienced and understood. It thus follows that what constitutes effect can never be separated from the persons involved. Effect can, in other words, never be taken for granted; it needs to be explored in relation to its context. In our study, this means the context of group-based lifestyle programmes in which patients participate in exercise interventions organized by physiotherapists seeking to help them lose weight.

Method

In our approach to this study, we were inspired by the hermeneutic-phenomenological method as described by van Manen (1997, 2014). Unlike research approaches emphasizing standardized interventions, a hermeneutic-phenomenological approach finds its point of departure in *lived experience* (1997, p. 18). Describing as well as interpreting participants' experiences, including their reflections on them, the researcher seeks to discern a deeper meaning of the subject matter (van Manen, 1997, p. 62)**.** In addition, this approach asserts an attitude of wonder and thoughtful attentiveness as essential in order to gain insight into another person's experiences. In other words, the researcher needs to be curious and sensitively attuned to what the participant is communicating explicitly and implicitly (van Manen, 1997, pp. 25-38). In focusing on individuals' lived

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experiences of various phenomena and situations, a hermeneutic-phenomenological approach is orientated towards revealing the *uniqueness* of human experience and does not allow for empirical generalizations. As van Manen (1997) states: "Generalizations about human experiences are almost always of troublesome value" (p. 22).

In accordance with a hermeneutic-phenomenological approach as outlined by van Manen, the focus of this study has been on describing and interpreting physiotherapists' experience-based knowledge as it acquires significance in their encounters with patients diagnosed as obese. Acknowledging that lived experience is often hidden or veiled, we have sought to uncover *thematic aspects* of their experiences (van Manen, 1997, pp. 88-92). Uncovering thematic aspects was a process that started during the interview process as the first author (Groven) conducted *conversational* interviews (van Manen, 1997, p. 66). In these interviews – which were conducted individually with 8 different physiotherapists – she encouraged each of them to elaborate on his or her own development as a clinician, starting from their years as novice clinicians to their current situation as more experienced clinicians. Finally, she asked them to reflect on how their approaches had changed during their years of working in the clinic specializing in group-based interventions for patients diagnosed as obese. In keeping with van Manen's recommendations, Groven sought to be concrete in asking follow-up questions, such as encouraging the participants to think of a specific situation, patient or episode. For example, when talking about how their approach had changed as they gained more clinical experience, she encouraged them to provide examples of specific episodes or situations. Such an approach proved valuable, resulting in detailed accounts of how they had come to rely on their experience-based knowledge. Although they did not use the term "experience-based knowledge" explicitly, their repetitive use of certain phrases, metaphors and examples illuminating the significance of relying on one's own experience pointed to a somewhat different approach from what comes across as the hierarchic way of finding best evidence as emphasized by proponents of EBP.

Listening to the physiotherapists' responses as they talked about their various experiences, some phrases seemed particularly relevant in illuminating thematic aspects of their development as clinicians. In the first interview, for example, Simon elaborated on how his personal experiences of struggling with obesity had "*shaped his approach*" so that he regarded himself as more attentive than other physiotherapists when communicating with patients struggling with obesity. Wondering about this, Groven came to focus on how the other physiotherapists elaborated on their personal experiences as *shaping* their approaches. In the interview with Nora, her use of various phrases and metaphors involving "experience" as something more relevant than research seemed relevant and somehow related to Simon's way of expressing himself, while at the same time indicating that there were some major differences in their backgrounds and thus also clinical experience. Finally, in the interview with Karin, her emphasis on finding links between her pain problems and those of her patients seemed to indicate that personal experiences indeed acquired significance in the clinical encounter. If so, how did these physiotherapists draw on their own experiences in various settings and situations? How, too, did physiotherapists juggle their own experiences with those of their patients while at the same time being in charge of a group-based programme emphasizing effect in terms of measurable results, including weight loss? Were there any tensions "hidden" in their development as clinicians? Put differently, were there any tensions between being in charge of the group while at the same time relating to patients' individual needs and desires? Inspired by van Manen's selective reading process, such *analytical questions* guided us further in our analysis as we read the transcribed interviews line-by-line. Statements and episodes that dealt with these questions were then highlighted and given different thematic headings. During this process, we found it useful to draft "thematic narratives". By writing and re-writing thematic aspects of Simon's, Karin's and Nora's development as clinicians, we sought to illuminate what was unique about the experience-based knowledge of each, while at the same time comparing their unique experiences with those of the others. In doing so, we could identify common threads and contrasting aspects in their experiences, pointing to a core theme: *the significance of experience-based knowledge in making individual adjustments*.

This core theme will be presented through thematic anecdotes. According to van Manen, "An anecdote is a certain kind of narrative with a point, and it is this point that needs honing" (van Manen, 1997, p. 69). In presenting our findings, we have sought to "hone" the core theme – *the significance of experience-based knowledge in making individual adjustments* – preparing the ground for a more critical discussion of the predominant hierarchy in EBP: a hierarchy giving priority to the therapeutic method as an indicator of effect. In other words, in our discussion, we question whether the therapeutic method itself (which is what is emphasised in randomized controlled trials) can in fact be given such primacy in defining best evidence and thereby effect.

Findings

Sporty and active, but interested in helping others

The participants described their own lifestyle prior to starting working as physiotherapists as being actively involved in various sports activities, such as handball, football and cross country skiing. Indeed, most of them

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were not only exercising on a regular basis, but also participating in various sports competitions. Their active lifestyle had been a part of their daily lives since early childhood and was associated with positive experiences. As Nora put it:

> *I have played soccer on a fairly good level. And, in general, I enjoy exercising, I try to be as active as I can … in a way, I am actually used to being active, an active exerciser, yes*.

In similar vein, Karin elaborated on her positive experiences with handball:

> *I quit a few years ago, because of injuries and things like that, but I have been active in a handball club, also as a physiotherapist for a while, and I have completed several courses in sports medicine, and exercise courses; and that is, of course … I have always loved being active and exercise on a regular basis, I absolutely have*.

As indicated in this extract, Karin's experiences of sports also involved experiences of being injured. In particular, her knee became increasingly problematic, so that she had to "quit", finding alternative ways of being active and exercise on a regular basis.

Simon shared similar experiences of engaging in sports. At the same time, his experiences differed from the others' in that he also had experiences of weight gain and obesity. Having been active in cross-country skiing from early childhood and competing (at a high level) for many years, he virtually "quit overnight" when he was 18. Having been used to eating whatever he desired without having to consider his weight, given his intense exercise regime, exercising up to 12 hours a week, Simon now experienced increasing weight gain. Indeed, he reached a point when he became, in his own words, "overweight", and he could sense people staring at him. People kept commenting on his changed appearance, and, as a physiotherapy student, Simon felt ashamed of being different from the others. Determined to resolve his obesity problems, he started exercising on a regular basis, and succeeded in losing weight and becoming "normal weight". For Simon, his personal experiences of gaining and then losing weight inspired him to apply for employment at a clinic specializing in lifestyle interventions:

> *For a period I was overweight myself. … I "hit the wall" in terms of exercise and quit almost overnight. And … I noticed very quickly that I was moving in the wrong direction. Eh …I realized that it is moving in the wrong direction in terms of my weight*.

As indicated in these extracts, sports participation and regular exercise have been an integral part of Nora's, Karin's and Simon's lives prior to, during, and after completing their physiotherapy training. In what follows, we will look more deeply into their accounts, exploring how personal experiences acquire significance in their work as physiotherapists aiming to help patients with obesity to change their lifestyle and thereby lose weight.

Simon

It has shaped my approach to patients and where my focus is

For Simon, drawing on his own experiences had become an integral part of his approach as a physiotherapist. Having worked in a private clinic for a short period, treating patients with various diagnoses, Simon found his experiences even more valuable when he started working as a physiotherapist in a clinic specializing in helping people with obesity. In particular, he found his own experiences valuable when communicating with patients about how to become more active. In his initial encounter with individual patients, Simon usually focused on identifying "realistic" (activity) goals – and in order to do this, he sought to involve his patients as much as possible, asking various questions with regard to their desires and preferences as well as hindrances. However, given that he at this point did not know the patient, it was somewhat challenging to know how to address sensitive issues such as previous experiences of weight regain, eating problems, or negative experiences with exercise and physical activity. In such situations, Simon found it paramount to draw on his own life experiences. In particular, he felt that his personal experience of being overweight, and also his subsequent efforts to lose weight, made him more attentive to and understanding of his patients' experiences.

Simon's personal experiences helped him tune into his patient's experiences, so that he could be more sensitive to their needs and desires. However, he acknowledged that, even though he had experienced being overweight himself, his patients' experiences were unique to them and different from his own:

> *I guess those experiences make you think differently when meeting people struggling with obesity compared to a physiotherapist who has always been normal weight and fit. Your perspective changes when you have been standing for a while on the other side of the fence. You have to respect the problems here; that this has to be on their own terms, supplemented with good guidance … . And how I would have experienced a physio-therapist standing over me telling me exactly what to do all the time. So, it has shaped my approach to patients and where my focus is*.

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Acknowledging differences and similarities between his experiences and those of his patients, Simon strove to find individual adjustments.

Individual adjustment involved being sensitive to each patient's unique situation in agreeing on *realistic* goals. For some patients, this meant starting out with the goal simply of walking around the house or to the mail box once a day:

> *Some of my patients are afraid of moving outside their house, and will only leave their house when they have a doctor's appointment, and other things that they have to do, because they struggle with anxiety and socializing with others is very hard for them. And for them going for a long walk with the rest of the group is a major barrier. And talking with them about these matters, we agree that the first goal is to walk to the mail box or around the house, or if they live in an apartment, walking down the stairs and back up again …and in the beginning it is not about doing this every day, but perhaps once a week. And when they feel that they can do so, then we try to increase it to twice a week.*

Emphasizing individual adjustments, Simon at times found himself challenging evidence-based knowledge:

> *So, it is all about establishing these starting goals, walking to the mail box every week. … And if you think about the advice from the health authorities here, about being active for at least 30 minutes every day, it is not even close. But you have to start where the patient is*.

Individual adjustments also involved establishing what Simon termed an "activity foundation". Drawing on his own experiences of hitting the wall, feeling sick and tired of exercising and pushing himself, he strove to help patients find *meaningful* activities – meaningful in the sense that, along with finding that they could manage to perform these activities, they would experience them as meaningful in their daily lives. This "activity foundation" was agreed upon so that the patient would feel confident that this was indeed something that he or she could accomplish:

> *So we try to make a structured plan, defining time and date and what to do and why. So I focus a lot on talking to the patients so that we can establish an "activity foundation" as I usually term it. And we try to make this foundation solid, so that it is 100 % realistic*.

When using the phrase "we" here, Simon refers to his emphasis on spending time communicating with his patients on an individual basis in establishing "activity foundations". As such, it was a foundation that he and his patient developed together. These conversations he found to be paramount in order to make individual adjustments in accordance with each patient's needs and unique situation. For some patients, struggling with complex problems, participation in the group-based programme at the clinic represented a threat to their establishment of an *activity foundation*. Accordingly, Simon was careful not to push them into participating in the group-based activities at the clinic. For others, individual adjustments were emphasized along with their participation in the group-based programme. For some patients, this could involve bicycling for 45 minutes emphasizing 60% of maximum pulse, for others 70-80% of maximum pulse, and for yet others, bicycling without paying attention to their pulse while aiming instead for 45 minutes of bicycling without stopping.

Karin

I've experienced some of the things that people with obesity struggle with

Like Simon, Karin found it useful to draw on her own experiences as a means of finding individual adjustments for her patients. In particular, Karin drew on her own experiences related to when she had to give up handball because of a severe knee injury. Pain and discomfort dominated her experiences when trying to rehabilitate, with the consequence that she had to explore alternative ways of being active. This involved being sensitive to where to draw the line in order to prevent the pain being provoked too much, while at the same time acknowledging that the pain could not be ignored:

> *I've experienced some of the things people with obesity struggle with. And I show them that, despite injuries, it is possible to take part in various activities and exercise. Many of them have pain in their knees generally and many of them have arthrosis because of their obesity. … A patient might feel like running, so I have to tell him that I do not think he should run … at least that he should also try other ways of being active. Many of them want to run, they want to run because it is effective in terms of weight loss*.

Drawing on her personal experiences, bearing in mind some of her own struggles, Karin helps her patients deal with their pain. In particular, she acknowledges their pain, and provides advice as to how each patient can go about finding alternative ways of exercising. For some patients, this means explaining that (too much) running might do more harm than good in terms of the pain, despite its "effectiveness" in terms of weight loss. Accordingly, she encourages them to explore how much running they can safely engage in, as well as the

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intensity of their running. For some patients, running might be replaced by other activities of a kind that do not provoke pain or bodily discomfort. As such, her approach is similar to Simon's in terms of her own emphasis on individual adjustments, rather than sticking to a standardized exercise programme. She allows for variation within the group setting so that patients can explore ways of participating on their own terms. In other words, rather than emphasizing standardization in the sense that everybody is expected to do the same, she encourages patients to be sensitive to their own needs and goals.

In emphasizing individual adjustments, Karin has come increasingly to question whether weight loss should in fact be the desired outcome for everybody in the group programme. Through her encounters at the clinic with patients experiencing weight regain, she has become more sensitive to the fact that shame and weight regain are closely related and that she as a physiotherapist can potentially intensify such patients' sense of shame by reproaching them for not having adhered to the advice they had been given during their stay at the clinic:

> *Talking about their weight regain once they return here is hard for the patients. They often feel that they have to stand trial for us. They feel ashamed and embarrassed about regaining weight. Many feel ashamed for failing. So it is obviously challenging to have such conversations about their weight regain.*

Over time, Karin has become increasingly ambivalent in respect of addressing weight regain with her patients. It is part of the clinic's policy to emphasize weight loss, in line with national guidelines, yet she herself regards too much emphasis on weight loss as a risk in terms of intensifying patients' sense of shame. Consequently, Karin tries to be sensitive to each patient's situation, emphasizing other outcomes for those who have "failed" to lose weight. In this way, she endeavours to avoid triggering their sense of shame:

> *Because, even though many might not lose as much weight as we want them to, most of them do experience more empowerment in their daily lives, they have more faith in themselves, they manage to stay at their work longer, they are fitter ... there are so many more positive aspects that they gain related to health issues than just their weight. You easily get hung up on those objective weight data.*

Objective data falls short of acknowledging patients' individual experiences relating to meaningful aspects of physical activity. Over time, Karin has increasingly come to question whether she and her colleagues are in fact doing the "right thing" – emphasizing measurable, objective data – given that many of the patients regain weight. Taking a deep breath at the end of our interview, she notes the following:

> *I am actually not sure whether I am going to continue working with this ... . I feel a lot on that part here, that people regain their weight, so is it really working what we are doing? For some it does, and for many it does not. So I feel in between that I question whether we are doing the right thing here. So is this what I will continue working with for the rest of my life? I feel a bit, that – yes, what shall I do to make patients succeed? How can I contribute to that? Yes, so I'm not sure whether I will continue working here.*

Karin is grappling with her ambivalence on her own. She finds it challenging to address her concerns with colleagues. Being part of a clinic in which focusing on effect and measurable outcomes is given priority, it is hard for her to change the way they do things. She can adjust her own way of approaching patients, in terms of how she communicates with them and helps them in finding adjusted activities. However, measuring patients' weight is standard procedure – and therefore part of her job. Given this, it is perhaps no wonder that she would consider changing her area of work rather than trying to change her clinic's emphasis on weight loss as a measurable indicator of success for patients.

Nora

Each patient is different, there is no blueprint

Having worked for five years in the same clinic, Nora feels far more confident now as a clinician than she had on first starting there. Reflecting on her *uncertainty* at the start of her career, she concludes that her confidence has first and foremost been gained through encounters with various patients:

> *It absolutely has to do with experience. ... And I came directly from school, so to speak, when I started here. And I thought, where can I read about this? And then I realized that I just have to experience this ... it is first and foremost experience-based, what I do here. And, of course, I have learned a lot about arthrosis and musculo-skeletal problems; right, that* [kind of knowledge] *I have with me here, but when it comes to finding the right dose and intensity with regard to exercises, that part of it I feel is first and foremost experience-based. ... Because each patient is different, there is no blueprint ...*

For Nora, it has been useful reflecting on what she

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learned as a student as compared with what she needs to know as a physiotherapist. Reflecting on this, she identifies a knowledge gap – a gap she has managed to narrow, thanks mostly to experiences acquired through her professional encounters with patients. Emphasizing that experience is "gold", and that her encounters with patients are a unique source of knowledge as to what works and does not work, she seems to indicate that, for her, "evidence" cannot be found through either standardized recommendations or research. In other words, her knowledge gap has been narrowed through her encounters with various patients – patients who differ from each other due to their unique experiences and unique situations as individuals; patients who do not fit into standardized interventions.

Summing up what she has found most valuable in terms of clinical experience, Nora notes how she has become more confident as to how to adjust activities, dose and intensity for individuals within the group setting:

> *The greatest challenge here for me has been – or what I have gradually experienced as paramount in order to be a good physio-therapist for my patients – that had to do with adjusting dose and intensity, and that I feel has been experience-based. I have to adjust the group activities individually, because they struggle with various things – arthrosis, knee-problems, breathing problems and so on. … So, although this is a group-based programme, I have to make individual adjustments*.

Acknowledging that each patient is unique, and thus different from the others, she has learned how to make individual adjustments, rather than putting the emphasis on expecting everybody in the group to do the same. In contrast to standardized group interventions, she has, in other words, learned the value of being sensitive to each patient's unique situation.

For Nora, her years in the clinic have changed her approach, in so far as she has become more sensitive to the diversity among patients. This change in focus has meant looking back on her novice years somewhat critically:

> *You do change because of all the experience, both in terms of my own approach to my patients and the way I communicate with them. So my reflections on these matters have changed a lot during these years … . Because it is a diverse group of patients in many ways; they are different people with different backgrounds and experiences. When I started here, I guess my way of thinking resembled most people's … : "The bottom line is to eat less and exercise more"*.

As a sporty and fit physiotherapist, Nora started working in the clinic eager to help patients change their activity habits. Drawing on her experiences of being active in football, being part of a team, as well as the common perception of obesity as a matter of eating the wrong food and lack of physical activity, she was hoping to use her own expertise in helping her patients become more active through exercising in a group-based programme together with others in the same situation. Being part of a group, and doing the same activities as the rest of the group, could serve to inspire participants to become more disciplined in terms of pushing themselves to keep up with the others. However, through her encounters with patients, Nora's goals have been subject to ongoing adjustments, acknowledging that ongoing dialogue is paramount as a means of making individual adjustments:

> *Each and everyone has their own story, including their own explanation as to why things have developed the way they have. So the group comprises healthy and fit individuals without any particular pain-problems; and then you have others who have not been active for years. So you have a lot of variation within the group, I would say, even though they come here with the same diagnosis. So for me it has been a big challenge finding ways to adjust individually within the large group. Even though we may divide the group into three sub-groups based on physical tests measuring their aerobic capacity and physical function level, there is still a lot of variation; for example you have those who have problems managing stairs and getting up from the floor and things like that*.

For Nora, dividing the group into three levels – based on objective tests – represents a different kind of knowledge – and thus also evidence – compared with the knowledge gained from her clinical experience of being in charge of the groups. Being in charge of all three groups, at different times, she has gained insight into the diversity among patients, as well as how to go about subtly adjusting activities within the standardized programme so that patients could each exercise in ways they felt were meaningful and effective for them. This has not, however, been a straightforward process. On the contrary, Nora has experimented with various ways of adjusting activities, in particular in terms of adjusting dose and intensity.

Over time, gaining more experience, Nora has found ways of being sensitive to each patient's needs and goals when making these adjustments. In particular, she has learned the value of being in ongoing dialogue with her patients, emphasizing that, in order to make individual adjustments, they have to explore how to do this, in

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various settings and contexts. There is no blueprint here, so she is dependent on each patient's response and feedback. In order to know whether she has succeeded in making appropriate individual adjustments, Nora is on the alert prior to, during and after various activities. Being on the alert means observing attentively as well as communicating with her patients, encouraging them to give her feedback in respect of how they experienced various group sessions:

> *My experience is that it is a delicate balance between what patients experience as pressure and feeling not being good enough, which might turn into a feeling of having failed rather than feeling that this is something they can master. And if it ends up so that they do not want to exercise more, or that they stay at home or things like that, then I have pushed too hard*.

On occasions when Nora is told by patients that she had pushed them too hard, being too optimistic or ambitious in her exectations of them, she values their feedback, as well as her own reflections on the episode concerned, as part of her "experience box".

Nora's use of "experience box" as intimately related both to her own experiences and those of her patients indicates that she has come to rely on clinical encounters as paramount, guiding her as to how to make individual adjustments. As such, clinical experience comes across as more relevant and context sensitive than external evidence stemming from research-based knowledge.

Discussion

In our findings and analysis, we have illuminated how physiotherapists make use of experiences *both* from their own life and from learning and doing physiotherapy. This multifaceted experience-based knowledge is significant in respect of being sensitive to each patient's needs and potentials. In the discussion that follows, we will focus on experience-based knowledge as paramount evidence different in kind from (external) evidence as a proclaimed understanding of knowledge in evidence-based practice.

Striving to make individual adjustments appropriate to every patient's needs and potentials is a main concern in therapy (Bjorbækmo & Mengshoel, 2016; Ekeland, 2009; Greenhalgh & Howick, 2014)**.** Simon, Nora and Karin increasingly developed their sensitivity to *each patient's uniqueness* – a sensitivity that enabled them to identify each patient's needs, desires, challenges and potentials. In doing so, they increasingly came to understand that, since exercise and physical activity is experienced differently among their patients, *group-based standardized activities for everybody in the group is not likely to be effective for all* of them in terms of weight loss. In this regard, they seemed to embrace a phenomenological view of the body, which values uniqueness and heterogeneous understandings of what constitutes effect (Nicholls & Gibson, 2010; van Manen, 2007). Increasingly the physiotherapists learned that what constitutes *effect* can in practice never be separated from the individuals involved. Their clinical experience thereby comes to stand in contrast to what is considered effect in evidence-based practice related to obesity research, namely the emphasis on weight loss as an indicator of progress and thereby also success.

In contrast to Simon and Karin, Nora had no personal experience of being overweight or injured while taking part in sport to draw on in her clinical encounters with patients. Nevertheless, her reference to her "experience box" as intimately related both to her own experiences and those of her patients indicates that she increasingly had come to rely on clinical encounters as paramount in guiding her making of individual adjustments. As such, clinical experience emerges as more relevant and context sensitive than research-based knowledge. Taken together, the physiotherapists' emphasis on developing individualized approaches can be related to Grimen's notion of *therapeutic effect*, which calls our attention to how the therapist approaches patients; for example, how he or she communicates with them (Grimen, 2009, p. 206). As such, there are thus different kinds of effects involved, with these related not only to the treatment itself, but to the therapists involved in the treatment. Nevertheless, as Grimen points out, such effects are not regarded as "evidence" in the methodological hierarchy that predominates EBP. Indeed, the methodological hierarchy of EBP suggests that there is only one best way of finding out what works. Although Grimen's arguments are based on his experiences in educational research and psychotherapy, they are highly relevant too within the field of physiotherapy research. Indeed, as indicated in our introduction, randomized controlled studies predominate in this area, culminating in clinical guidelines and treatment recommendations. However, as illuminated by Nora's clinical experiences, *what works for one patient does not necessarily work for another patient.* Through experience, she has learned the value of being sensitive to variations among her patients, which impacts on how she approaches them and how she guides and supports them. Her approach is, one could argue, *more experience-based* than evidence-based. In her clinical encounters, she relies more on her own clinical experience than on "evidence" deriving from randomized controlled studies emphasizing effect as a result of intense and regular exercise interventions. As such, one could argue that she turns the evidence-based hierarchy upside down, downplaying external evidence (i.e., research-based knowledge privileging randomized controlled studies) in the sense that her clinical experience becomes, for her, the gold standard. Campos, Beckenkamp, and Moseley (2013) assert that

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practising evidence-based physiotherapy involves a step-by-step procedure starting with locating high-quality research. Indeed, whereas accessing research-based knowledge – "tracking down the *best evidence* to answer the question(s)" – is given priority as to what to do first, integrating "best evidence" with experience-based knowledge – or "clinical expertise" as they term it – is placed last. Such a step-by-step approach suggests that physiotherapists' clinical experiences should be toned down or placed in parenthesis until after they have systematically searched for best external evidence through bibliographic databases in order to identify high quality research. As Campos et al. put it:

> The best evidence (or highest level evidence) for answering clinical questions about the effects of intervention are reports of systematic reviews of randomized controlled trials or reports of individual well-conducted randomized controlled trials and evidence-based clinical practice guidelines. (Campos et al., 2013, pp. 252-253)

The physiotherapists in our study did not explicitly state that such a step-by-step approach favouring some kinds of research over their clinical experience was somewhat problematic. Nor did they emphasize or talk about the significance of finding best evidence by way of such a stepwise procedure. Indeed, they hardly talked about randomized controlled studies at all. What they did talk about, however, was how they found it challenging finding relevant literature regarding how to make individual adjustments for patients in a group-based programme. Moreover, their joint emphasis on clinical experience and the value of relying on their own as well as their patients' experiences indicates that this was given high priority in their clinical work. Given the *complexity* of patients' situations, as well as the variation among their patients, they had to be sensitive to each person's needs and goals. Being sensitive to patients' unique situations involved challenging external evidence in respect of pre-defined intensities and types of activities, such as instructing individuals with obesity to exercise at least 30 minutes a day. As such, their approach finds support in Merleau-Ponty's view of embodied knowledge as sensitive to the meaning of the situation as a whole, valuing the body as unique, subjective and relational: *"It is never our objective body that we move, but our phenomenological"* (Merleau-Ponty, 1945/ 2002, p. 121). In other words, evidence, in the sense of what works and what does not work for a patient diagnosed as obese, cannot be reduced to *external* evidence, something that physiotherapists can measure on a scale, as the body is not to be regarded as an object, but as a sensing and moving body subject.

By being attentive to their patients' unique experiences, both comparing them with and contrasting them to their own, the physiotherapists increasingly came to rely on their bodily sensations as a unique source of knowledge. As we recall from Karin's account, she felt *ambivalent* as to her own approach when patients regained weight. Her ambivalence was related to her sense of the risk of doing more harm than good, particularly in terms of triggering patients' sense of self-blame and shame. In other words, rather than addressing the issue in terms of their not having tried hard enough, she increasingly came to question her own approach. This points to a situational discrepancy between life and learning; that is, a discrepancy between, on the one hand, external evidence regarding weight loss as a matter of eating less and exercising more, and, on the other hand, the complexity of individual lives as not compatible with evidence stemming from effect studies. As Merleau-Ponty reminds us, ambivalence is the "essence of human existence" so that "everything we live and think has always several meanings" (1945/2002, p. 196). Viewed in such a light, failure to lose weight emerges as an ambiguous phenomenon involving both the patient and the therapist. In other words, *ambiguity* served as a bodily intuition that one had to change approach by toning down the significance of weight loss and focusing instead on other outcomes – outcomes that could be sensed as meaningful in patients' daily lives, such as managing to climb stairs without feeling exhausted. In similar vein, Nora elaborated on how her approach had changed over the years, as she came to be more sensitive to patient's unique experiences. This change was, first and foremost, experience-based. Randomized controlled studies emphasizing standardized group-based interventions were not attuned to the complexity of patients' life-worlds. Behind their shared diagnosis, they were different people with different experiences. During her encounters with various patients, Nora had thus increasingly come to question commonly held views: "it was not a matter of eating less and exercising more". Nora's reflections on these matters point to the significance of acknowledging the *limitations* of standardized interventions, trusting her experienced-based knowledge as a unique source of knowledge.

Taken together, Nora's and Karin's experiences echo Ekeli's scepticism as to the hierarchy of knowledge that predominates evidence-based physiotherapy (Ekeli, 2002). In order to adjust their approach to patients' unique needs and goals, physiotherapists need to take into account the more *tacit* aspects of their experience-based knowledge. These experiences cannot necessarily be expressed in words. Just as important here are bodily feelings – or intuitive sensations – that arise there and then in the clinical encounter. When physiotherapists learn how to trust these sensations as a valuable source of knowledge, they can more adequately relate them to relevant research. As such, experience-based knowledge can serve as a guide to how to include relevant research. Such a stance involves redefining the predominant hierarchy in EBP. A new pendulum shift towards

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acknowledging systematic and critical reflections based on years of clinical experience and then a careful consideration as to the relevance of research? Along much the same lines, Engebretsen et al. (2016) point to the overall aim of EBP to reduce health professionals' sense of *uncertainty* through its use of standardized treatment approaches. Rather than disregard uncertainty, they argue for the need for uncertainty to be regarded as a productive aspect of EBP, enabling health professionals to make more individualized, and thus demonstrably also more effective, clinical decisions;

> Uncertainty is not a regrettable and unavoidable aspect of clinical decision making but a productive component of clinical reasoning. (Engebretsen et al., 2016, p. 136)

In other words, reflecting on their sense of uncertainty in clinical situations can help health professionals adjust their approach in accordance with the patients' needs as well as clinical guidelines.

Within the physiotherapy profession there has been little critical debate regarding EBP.[4] Indeed, when evidence-based physiotherapy is debated, it is emphasized, first and foremost, as a moral and professional obligation in order to ensure effective and unbiased treatment to the benefit of the patients (Dannapfel, Peolsson, & Nilsen, 2013). For example, in their widely cited article in *Physiotherapy Theory and Practice*, defending evidence-based practice as "imperfect, but necessary", Herbert, Sherrington, Maher, and Moseley (2001) sum up what they consider to be the "overwhelming" strength of evidence-based physiotherapy:

> It takes full advantage of the *only potentially unbiased estimates of effects of therapy* – those ... derived from carefully conducted clinical research. (Herbert et al., 2001, p. 201; emphasis added)

As indicated in this extract, effect is related to the physiotherapy approach itself, whereas physiotherapists' clinical experiences implicitly seem to be regarded as *a biased source* of knowledge. Similar assumptions are echoed in empirical studies on physiotherapists' use of standardized clinical guidelines. For example, in a study on physiotherapists' use of guidelines in various clinical settings in Sweden, standardization was regarded as a means of ensuring that patients were offered the *same* tests and the *same* treatment. As one of the respondents put it:

> We want to treat our patients in the same way. They should get the same tests and treatment regardless of whether they consult me or anyone else. It [using research] is a kind of quality assurance. (Dannapfel et al., 2013, p. 4)

In contrast, our findings point to the significance of *individual adjustments* as a means of ensuring meaningful outcomes on the part of the patient. Rather than emphasizing standardization, ensuring that every patient gets the same treatment, treatment should optimally be individualized. In doing so, effect needs to be negotiated there and then in the clinical encounters, as, to paraphrase Nora, what works for one patient might not work for another. Our findings thus point to the need for *acknowledging experience-based knowledge* as an indispensable and paramount source of knowledge in helping patients find individual adjustments.

Concluding Comments

Evidence in the sense of what works and what will be effective therapy for a person diagnosed as obese cannot be reduced to external evidence. Proceeding from a hermeneutic-phenomenological frame of reference, we have demonstrated that there is a need in clinical practice to rely on experience-based knowledge in order to make individual adjustments for patients. In and of itself, the therapeutic method cannot, despite the emphasis on it in randomized controlled trials, define best evidence and thereby effect. Physiotherapists' clinical experience focuses on a different hierarchy, namely the need to rely on experience-based knowledge.

In order for physiotherapists to approach patients with obesity in a more individualized manner, the hegemony of randomized controlled interventions needs to be challenged. To this end, physiotherapists should be encouraged to draw on, and learn from, their own experiences as well as those of their patients. Such experiences should be regarded as the gold standard and paramount in clinical practice.

[4] There has been some debate regarding the need to acknowledge qualitative studies as part of the external evidence – see, for example, Schreiber & Stern (2005).

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About the Authors



Karen Synne Groven
Postdoctoral Fellow
Institute of Health and Society
University of Oslo, Norway
E-mail address: k.s.groven@medisin.uio.no

Karen Synne Groven is an Associate Professor in the Institute of Physiotherapy at Oslo and Akershus University College of Applied Sciences, and holds a postdoctoral position in the Institute of Health and Society at the University of Oslo, where she is currently engaged in a project exploring adolescents' experiences of participating in a group-based lifestyle programme.

Associate Professor Groven's active research interests are in the fields of obesity, chronic illness and pain problems. In this regard, her research approach also focuses on evidence-based treatment interventions, including conservative and surgical interventions as experienced from both patients' and health professionals' perspectives. Her doctoral research focused on women's life-situation following weight-loss surgery.

Kristin Heggen
Professor
Department of Health and Society
Faculty of Medicine
University of Oslo, Norway
E-mail address: k.m.heggen@medisin.uio.no



Kristin Heggen is a Professor in the Department of Health and Society at the University of Oslo, and is currently serving as Dean of Education in the Faculty of Medicine.

Professor Heggen's research interests comprise ethical issues and power dynamics in health care as well as medical humanities, and issues concerning education and knowledge transfer between academic and clinical settings. She is particularly interested in the foundations of evidence-based medicine and "knowledge translation" as an intellectual, social and discursive process, especially in the domains of the humanities, social sciences and educational research.

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