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**PERSONAL EXPERIENCE OF SUFFERERS FROM WHIPLASH
INJURY COMPARED TO THE EXPERIENCE OF DOCTORS
MANAGING THE CONDITION**

FRANCES DOREEN ROGERS

A thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Philosophy

The University of Huddersfield

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To Geoff Sparks
Without his encouragement and support this
journey would not have begun.

Abstract

This qualitative study takes an interpretative phenomenological approach to understand the experience of whiplash injury from the different perspectives of patient and doctor. This was carried out in order to identify what psycho-social consequences might be experienced by patients as a result of that injury and to identify any implications for healthcare provision.

The research was conducted in two phases. During Phase One, eight patients were recruited through GP practices using a combined approach of retrospective and prospective sampling. Three semi-structured interviews and one telephone interview were carried out with each participant over a twelve month period. In keeping with phenomenological methodology, data were analysed using Template Analysis (King, 2004) and a set of themes relating to healthcare experience were identified: 'embodiment' 'experience of pain' 'disruption to lifestyle', 'making sense', 'patient as expert' and 'whiplash: a minor injury?'.

During Phase Two, one semi-structured interview was carried out with eight doctors who worked in either the primary or secondary care settings. Data were analysed using Template Analysis and a set of themes relating to their experiences of treating patients was identified: 'expectations regarding what patients will experience', 'what patients do about their whiplash injury', 'what doctors do' and 'blame if things go wrong'.

These findings show how the patient participants' physical and psychological experiences of their malfunctioning body had consequences for maintaining their sense of self and their ability to carry out their normal everyday activities at home and work. The doctors' own expectations of treating patients with whiplash injury and whether or not they trust the patients' account have illustrated three approaches: dismissive, reactive or proactive that have different implications for patients' experiences of healthcare. The study shows how the notion of 'compensation' is implicated in whether or not the doctor feels able to trust the patient's account.

The implications of these findings can be seen in terms of methodological focus, general practice and policy formulation. Methodologically interpretative phenomenology provides a theoretical foundation that is, at the very least, equal to and able to challenge more 'traditional scientific foundations' through its focus on meaning. In terms of practice and policy formulation, the findings have provided a unique insight that might prove to be beneficial for understanding the health care experience and assist in the provision of guidelines aimed at the treatment of whiplash injury. Indeed it is advocated that doctors adopt a subjective approach and that this is taken into account in training.

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Chapter Contents

Chapter 1: Introduction	14
1.1 The beginning	15
1.2 Whiplash injury as a medical phenomenon	18
1.2.1 Whiplash: the development of a medical model	20
Diagnostic skills	23
1.2.2 Competing definitions of whiplash injury	23
1.3 Psycho-social issues	28
1.3.1 Pain	28
1.3.2 Psychological trauma	29
Travel anxiety	30
Post Traumatic Stress disorder	31
1.4 Thesis outline	32
Chapter 2: Understanding the Experience of Whiplash Injury	35
2.1 Compensation	36
2.2 The need for an integrated approach	42
2.2.1 The biopsychosocial perspective	43
Societal change towards sickness absence	48
2.3 Psychological approaches to understanding illness	56
2.3.1 Health Belief Model	56
2.3.2 Cognitive behavioural theory	57
Fear avoidance	58
Catastrophizing	59
2.3.3 Cognitive behavioural interventions in chronic illness	60

2.4 Towards a phenomenology of whiplash injury	62
2.4.1 Discourse analysis	64
2.4.2 Phenomenological approach	66
2.4.3 Embodiment	66
2.5 Aims of the study	70
Chapter 3: Methodology	72
3.1 Framing the research	72
3.1.1 Epistemological and ontological assumptions	74
3.2 Phenomenology	77
3.2.1 Development of phenomenology	78
3.2.2 Key ideas	81
Intentionality	81
Temporality	83
Epoché	83
Essence	84
Lifeworld	85
3.2.3 Descriptive versus interpretive phenomenology	85
3.3 Phenomenological research methods	87
3.3.1 Principles of descriptive phenomenological research	87
3.3.2 Giorgi's descriptive method	89
3.3.3 Interpretive phenomenological research	90
3.3.4 Principles of interpretive phenomenology	91
3.3.5 Phenomenological approaches to data collection	92
3.3.6 Interpretative phenomenological analysis	94

Analysis	94
3.3.7 Template analysis	95
3.3.8 Justification of chosen method	96
3.4 From theory to practice: the method	98
3.4.1 Design	99
3.4.2 Sampling and recruitment	100
3.4.3 Data collection	100
3.5 Negotiating access to trusts and practices	101
3.6 Ethical considerations	102
3.6.1 Informed consent	102
3.6.2 Confidentiality and anonymity	103
3.6.3 Protection of participants	103
3.6.4 Researcher safety	104
3.7 Obtaining ethical approval	104
Chapter 4: Phase One-Patients: Method	106
4.1 Design	106
4.1.1 Sampling strategy	107
4.1.2 Recruitment of GP Practices	108
4.1.3 Patient recruitment	110
4.1.4 Retrospective recruitment	111
4.1.5 Prospective recruitment	112
4.2 Sample	112
4.2.1 Participant profiles	116
4.3 Interviewing	117

4.3.1 Developing the patient interview schedule	118
First interview schedule	119
Second interview and Final schedule	119
Telephone interview schedule	119
4.3.2 Piloting the patient interview schedules	119
4.3.3 Interview setting	120
4.3.4 Interview process	120
4.3.5 After the interview	122
4.4 Analysis	122
4.4.1 Analysis: template analysis	123
4.4.2 Developing the template	124
Chapter 5: The Patients' Individual Stories	130
5.1 Martin: how will I manage?	130
5.2 Margaret: the expert now	135
5.3 Bill: 'Mr Grumpy'	140
5.4 James: now I know what it feels like	143
5.5 Linda: they said it was nothing, but it is	146
5.6 Rav: tell me, why me?	149
5.7 Steph: what if?	152
5.8 Hazel: there's still hope	155
Chapter 6: Thematic Representation of Patient Interviews	159
6.1 The Healthcare Experience	160
6.1.1 Treatment	161

NHS treatment	162
Other treatment providers	165
6.1.2 Information on whiplash injury	166
6.1.3 Participant evaluation of healthcare	166
6.2 Embodiment	168
6.2.1 Disrupted body movement	169
6.2.2 Experience of pain	171
Management of pain	173
6.2.3 Disruption to lifestyle	175
6.2.4 Changing sense of self	179
6.3 Making sense of their injury	182
6.4 Patient Expert	187
6.5 Whiplash: a minor injury?	189
Chapter Seven: Phase Two-Doctors: Method	192
7.1 Design	192
7.1.1 Sampling strategy	192
7.1.2 Recruitment	193
7.1.3 Sample	193
7.1.4 Participant profiles	194
7.2 Interviewing	196
7.2.1 Developing the doctor interview schedule	196
7.2.2 Piloting the doctor interview schedule	196
7.2.3 Interview setting	197
7.2.4 Interview process	198

7.2.5 After the interview	199
7.3 Analysis	199
7.3.1 Analysis: template analysis	199
7.3.2 The template	201
Chapter 8: The Doctors' Thematic Analysis	206
8.1 Expectations regarding what patients will experience	206
8.1.1 Expectations of lack of problems for patients	207
8.1.2 Expectation of minimal need for intervention	208
8.1.3 Expectation of possible problems for the patient	210
Medical problem	210
Psycho-social issues	212
Depression and stress	212
Incapacity	213
8.1.4 Additional factors impacting on patient experience	215
8.2 What patients do about their whiplash injury	215
8.2.1 Ulterior motives for focus on whiplash injury	216
8.2.2 Patients sometimes make it worse	219
Patients who ignore the doctor's advice	219
Illness behaviour and the sick role	220
Inappropriate use of the Accident and Emergency department	223
8.3 What doctors do	224
8.3.1 Deal with patients	225
8.3.2 Encourage patients to help self	226
8.3.3 Use NHS resources appropriately	228

8.3.4 Use personal experience	230
Chapter 9: Discussion	233
9.1 The psycho-social experience of whiplash injury	233
9.1.1 The malfunctioning body	235
9.1.2 Changing identity and changing roles	243
9.1.3 The context of a motor vehicle accident	247
9.2 Doctors' approaches to whiplash injury	249
9.2.1 Dismissive approach	250
9.2.2 Reactive approach	253
9.2.3 Proactive approach	255
9.3 Implications of approaches for patients' experiences	257
9.3.1 Dismissive approach	257
9.3.2 Reactive approach	259
9.3.3 Proactive approach	260
9.4 Trust	262
Chapter 10: Conclusion	268
10.1 Occupational implications	269
10.2 Allocation of healthcare resources	271
10.3 Implications for policy and clinical practice	274
10.4 Reflections on research process	277
10.5 Dissemination of findings	280
10.6 Recommendations for further research	280
10.7 Conclusion	282

References	284
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Appendices	301
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1: Letter to Trust Chief Executives	302
2: Invitation for patient recruitment	303
3: Whiplash study recruitment practice guide	307
4: Patient information	309
5: Patient ‘study’ acceptance form	313
6: Study confirmation	315
7: Participant consent form	317
8: LREC Approval	319
9: PCT Approval	321
10: Patient participant follow up	323
11: Interview guide: patients - first interview	325
12: Interview guide: patients - follow up	329
13: Telephone interview: patients	332
14: Interview guide: doctors	334
15: Initial template: patient data	336
16: Revised template: doctors	343

List of Tables

1 Patient participant characteristics	114
2 Break down of patient sample and interviews carried out	114
3 Summarised initial template: patients	126
4 Final template: patients	128

5 Summarised doctor profiles	195
6 Breakdown of doctor interviews	196
7 Initial template: doctors	201
8 Final template: doctors	204

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Chapter One: Introduction

Whiplash imposes unacceptable costs to individuals, businesses and the state. Insurers want to reduce whiplash, provide fast care and compensation and tackle fraudulent claims. But we cannot do this alone. We call on the Government, road safety groups, the medical and legal professions and other stakeholders to work with us on a campaign to reduce this problem.
(Stephen Haddrill ABI's General Director:2008).

Car ownership has grown rapidly over the last thirty years or so. According to the National Road Traffic Forecast (Department for Transport, 2004) it is anticipated that car ownership will increase by 46% between 1996 and 2031, from 23 million cars in 1996 to around 33.5 million cars in 2031. This has meant that motor vehicle accidents have become an all too familiar part of modern life and one of the things this leads to is whiplash injury. This thesis is going to explore whiplash injury which I would argue has been neglected despite its economic, medical and personal cost.

I am going to introduce this chapter with some personal reflections that arise from my own experience of having had a whiplash injury, before I go on to discuss both the prevalence and development of the medical model in this area. The reason for this is twofold: first, I wanted to show how that experience led to the development of this research study. Secondly, reflexivity is recognised as an important tool for the qualitative researcher. Gough (2003:22) suggested:

...reflexivity facilitates a critical attitude towards locating the impact of research(er) context and subjectivity on project design, data collection, data analysis and presentation of findings.

Coming from a background as a healthcare professional I was acutely aware that the charge of bias and lack of rigour, rightly or wrongly, was often ascribed to qualitative research. To overcome this charge and to make my use of 'self' transparent

throughout the research I wanted to try and incorporate both my act of reflection and my attempt to be reflexive throughout this thesis rather than wait until the concluding chapter.

1.1. The beginning

In 1997, I was working in the community as a health visitor. This meant that I spent a considerable amount of time in the car driving between clients' homes and the various venues that constituted the organisation. Whilst it might be stating the obvious that car accidents could be considered an occupational hazard for people who work in the community, the reality is that one does not dwell on this fact. I did not, other than to ensure my car had good safety features. On the day I had my car accident it could be said that I was in the right place at the wrong time as I was involved in a car accident at work. I remember describing myself as 'shaken up' but not injured, unlike my car which was a mess and I was glad that it had side impact bars as it was hit in the side. At the time of the accident I had no reason to believe that the outcome would be any different from the other car accidents that I had been involved in. I had expected to experience some discomfort and pain after the accident and I had decided that this was quite normal and I expected it to settle down by itself. How wrong I was in thinking that. A week after the accident I was still having problems which, if anything, were much worse. I finally decided that I should consult the doctor and make sure it was nothing serious. The doctor told me that I had a whiplash injury and this was the cause of my symptoms.

Eighteen months after my accident the problems I experienced from the injury continued and I found myself thinking: this cannot be right. How can I still have all

this pain and not be able to do the things I did before the accident? This did not make sense, after all a whiplash injury is a muscle sprain which is supposed to settle down after a couple of weeks. That was what I expected to happen. However, this time it was different, the whiplash injury was much more than a muscle sprain that was inconvenient for a few days. As I began to consider my situation, I thought to myself: surely I cannot be the only person to experience problems from a whiplash injury?

I thought back to my accident and the actions that I had taken. I had thought I was ok and continued to carry on with everything as usual and did not even feel that I needed to see a doctor. I only made the decision to see a doctor when I experienced a problem at work that made me think 'something was not quite right'. I was doing a routine examination of a baby and found that I had a problem in lifting the baby up to do the physical examination and was quite shocked by that. I could put up with the pain and stiffness but this was different. I thought maybe I had been wrong in my assessment that I had not been injured in the accident even though there was no obvious injury. I saw my GP who said 'it was a whiplash'. I asked him if my actions might have made things worse to which he replied 'I would have thought and done the same as you'. He prescribed an anti-inflammatory medication and advised me to have some time off work. Three weeks later I was so stiff that I could not even bend properly and was convinced that this had to be more than a whiplash injury. My spine felt as if it had seized up and I felt like something was different but I could not say what it was. By this time my GP was unable to convince me that this was normal and that it would settle down. After much discussion I was referred to an Orthopaedic Consultant. The consultant confirmed that it was definitely a whiplash injury and that I would also

need physiotherapy to treat the injury. I had not been told anything that might suggest I would still have problems more than a year after the injury first occurred.

With these thoughts in mind, my foray into the literature on whiplash started with a study by Gargan et al. (1997). This prospective study involved fifty consecutive patients who presented at an accident department after a rear-end collision. All the patients had been sitting in a stationary vehicle. As the onset of symptoms from a whiplash can be delayed all passengers in each vehicle were included whether or not they complained of significant symptoms. They recorded symptoms and psychological test scores using the General Household Questionnaire (GHQ) within one week, three months and two years of injury and recorded a range of neck movements at three months. Gargan et al. found that the psychological test scores carried out within one week of the injury were normal in 82% of the group. In contrast to this, three months later they used the same group of patients and found that 81% of the patients had developed intrusive or disabling symptoms. The same group of people were tested after two years when it was found that the psychological test scores remained abnormal in 69% of the patients who were still experiencing intrusive or disabling symptoms. Gargan et al. suggested that the psychological response developed after the physical response. The psychological response was seen as the patient developing a disorder such as depression or insomnia. They also suggested that the clinical outcome after two years could be predicted at three months with an accuracy of 76% percent by neck stiffness and 74% percent by psychological score or 82% with a combination of these variables. The psychological response was said to be established within three months of the injury and a large proportion of the patients appeared to reach a final stage of recovery or chronic symptoms within three months.

After reading this, I thought that maybe whiplash injury had a psycho-social impact. I was not sure what, but I wanted to know more. I found myself wondering what the psycho-social implications from having a whiplash injury were and what this actually meant for people. Through my own experience I had become acutely aware that the medical description of whiplash injury as a muscle sprain did little to account for the suffering that I had experienced as a consequence of the injury and this study suggested that others also suffered as result of whiplash injury. The health visitor in me also wondered whether or not these problems people experienced could be minimised or prevented and, if that was the case, what actions or strategies might be required. My own experience of the psycho-social effects of whiplash injury made me think about what takes place in the first consultation and how the injury is managed. This is because the symptoms the patient presents with at that time are also the symptoms that would be seen several months or years later. I wondered whether or not there were any consequences from the first consultation with the doctor, for the patient's experience of whiplash injury. Conversely, I also wondered if more was known about the psycho-social impact of whiplash injury and whether or not this might have implications for the management of whiplash injury. The seeds had been sown and my quest had begun.

1.2 Whiplash injury as a medical phenomenon

The preface (p1) to *The Road Casualties Great Britain 2006* showed the vehicle population in 2006 was 33 million vehicles and there were 189,000 injury accidents reported to the police. The number of casualties sustaining a slight injury in 2006 was 226,559. The Department for transport (DFT) (2006: 49) define slight injury as:

An injury of a minor character such as sprain (including neck whiplash injury), bruise or cut which are not judged to be

severe or slight shock requiring road side attention. The definition includes injuries not requiring medical attention.

To avoid any confusion being created between the terminology of 'slight' and 'minor' injury; I am going to use the term minor injury throughout.

One consequence of the increase in car ownership is the way in which motor vehicle accidents (MVA) are seen to have become a major source of injury in western society (Blanchard and Hickling, 1997). At the same time it has been noted that the incidence of whiplash injury has continued to rise and that this increase appears to be greater in those countries where it is compulsory to wear a seatbelt (Spitzer et al., 1995; Gifford, 1998). In the United Kingdom the increase in whiplash injury has been linked to changes in road accident rates along with seat belt legislation and the introduction of head restraints (Mayou and Radanov, 1996).

Whilst it has been possible to establish the level of increase in motor vehicle accidents, it has not been possible to establish the proportion of minor injuries that have been classed as a whiplash injury. There are several reasons why I have found this problematic. The first is related to the way the road accident statistics are collected by the police who have to make a decision as to whether or not an injury has occurred. Also, there is no way of differentiating between the different types of minor injury as they are all subsumed under the same category. The road accident figures do not take into account those who did not report the accident to the police as they considered themselves uninjured at the time, but may subsequently have attended their GP for treatment. The other reason is to do with the way health statistics are collected in the NHS. At present different systems are used to collect and hold

information about patients. This means that information about patients who present to the hospital Accident and Emergency department are collated and kept separately to those patients who are seen in Primary Care. When turning to data that is collected within the NHS the difficulty of establishing a true incidence of whiplash injury remains. This is because whiplash injury was not differentiated from other types of neck trauma and within Primary care the position is further complicated by the use of consultations to gather data on morbidity (McCormick et al., 1992). Whilst McCormick et al., (1992) classify diseases of the musculoskeletal system into Serious, Intermediate, and Minor and give the number of consultations for each category, it is not possible to identify specific conditions such as whiplash injury.

The fact that there is no differentiation of whiplash injury from other conditions is also an issue when trying to establish the range and severity of whiplash injury and potential impact for doctors' workloads. One way in which severity of the injury might be determined is through the application of mechanics where severity of the injury is related to the force of impact. The force of impact could be quite severe depending on the speed of the vehicles at the time of impact (Barnsley et al., 1994). McConnell et al. (1993) looked at the effects of low velocity impacts on human subjects. Low impact velocity is defined as speeds of 6-8km/h. They found that forces of up to 4.5G could be reached and suggested that this force was the threshold for mild cervical sprains. Jonnson et al. (1994) criticised this position as it is not possible to know the trajectory of forces, acceleration/deceleration and other biomechanical events that take place at the time.

Suissa et al. (2001) support Gargan et al. (1997) findings that whiplash patients who present with specific musculoskeletal symptoms such as the presence of neck pain or tenderness on examination, or there is pain or numbness radiating from the neck are more likely to have a longer recovery time. This suggests that the earlier a patient experiences the onset of pain then there is an increased likelihood that they that they might take longer to recover.

Waddell et al. (2002:3) suggest that about 1 in 200 people will have a minor neck injury or whiplash injury each year. It is not clear whether this suggestion is based solely on the numbers of people who have attended the Accident and Emergency department or if it is based on the whole population. Wallis et al. (2003) have suggested that a representative figure of 1 per 1000 population per year has been used to calculate the incidence of whiplash injury. If this is applied to the 226,599 known minor injuries in 2006, approximately 2266 people would have a whiplash injury.

Furthermore McClune et al. (2002) suggest that 50% of patients who have been diagnosed with a whiplash injury will not have recovered three months after sustaining their injury and that whiplash injury remains a 'substantial clinical and social problem' (McClune et al., 2002: 514). More recently the Association of British Insurers (ABI) have stated that over 430,000 people made a personal injury claim following a motor vehicle accident in 2007 and 75% of these claims were for whiplash injury (ABI, 2008). If that is the case then it is important, both locally and nationally, that healthcare provision is able to understand and respond to the way whiplash injury impacts on normal everyday life if these patients are not to be seen as a 'clinical and social problem'. I return to the issue of epidemiological information regarding whiplash injury in Chapter four.

1.2.1 Whiplash: the development of a medical model

The term whiplash was first used by Harold Crowe in 1928 when he defined whiplash as the effects of sudden acceleration – deceleration forces on the neck and upper trunk that often took place in a rear-end shunt (Crowe, 1928). The external forces produced the effect of a lash, hence the whiplash mechanism. The term whiplash at that time described a mechanism rather than an actual injury. A second definition of whiplash came into being when Farban (1973) incorporated the term whiplash into whiplash injury to represent a simple musculoligamentous neck sprain and excluded fractures. Musculoligamentous refers to the ligaments and muscles of the body. This became the accepted medical definition of whiplash injury which simply means an injury to the muscles or ligaments of the neck as opposed to other parts of the body.

During the late 1980s and early 1990s, symptoms that might be experienced from a whiplash began to be included within the earlier definition of whiplash as defined by Crowe. The symptoms of neck pain and headache that were reported by patients were also seen as being associated with the injury (Balla and Karnaghan, 1987; Pearce 1989). This was followed with the addition of other symptoms that were referred to as cognitive impairment (Yarnell and Rossi, 1988; Radanov et al., 1995). Cognitive impairment means difficulties with concentration and memory.

Very little attention appeared to have been given to the restriction in movements that might accompany whiplash injury. Since the term whiplash injury entered common usage it has become associated with motor vehicle accidents, although it can occur in other situations such as slipping on the ice or falling off a bike.

Whilst a clear definition of what constitutes a particular disease or condition is important for doctors, the giving of a diagnosis is one aspect of the clinical diagnostic process. The other part of the process is related to the doctor's clinical diagnostic skills and the way these skills are applied.

Diagnostic skills

The acquisition and application of clinical diagnostic skills is to some extent dependent on the stage and level of professional development the doctor or other clinician (Benner, 1984; Elstein and Schwarz, 2002). The different diagnostic skills that can be applied are known as Hypothetico deduction in which a limited number of hypotheses are formed quite early in the diagnostic process and used to guide the questions that the doctor might ask and Pattern recognition or categorisation in which the identification of patterns informs the diagnosis. Pattern recognition is seen as being largely uncritical and “useful for solving easy cases” (Elstein and Schwartz, 2002: 730).

1.2.2 Competing definitions of whiplash injury

The increasing incidence of whiplash injury has led to the existence of multiple definitions of whiplash injury that were often used interchangeably to describe whiplash injury (Livingston, 2000). This issue became important when it was recognised that not all patients were recovering. The lack of a single definition also made it difficult for those who undertook research into whiplash injuries as the studies often used different definitions. This was noticeable when researchers tried to compare the various studies that sought to improve our understanding of what

constituted whiplash, and identify what treatment[s] might be required for the condition (Livingstone, 2000).

The difficulties associated with the definitions of whiplash injury remained largely unchanged until the introduction of a report by the Quebec Task Force (QTF) in 1995. The task force was chaired by Walter O Spitzer and comprised a panel of experts in medicine, epidemiology, chiropractics, biostatistics and other disciplines. They were commissioned by the Quebec Automobile Insurance society during 1989/1990 to determine the extent of the problem that was attributed to whiplash injury and addressed issues that included the following:

- The prevention of whiplash injuries;
- The formulation of clinical guidelines for the diagnosis and management of whiplash injuries;
- The development of recommendations for occupational and personal rehabilitation for individuals with whiplash injury;
- The development of a strategy for the education of healthcare providers regarding whiplash injuries.

This piece of work was regarded as being important for several reasons. First, it became a milestone in applying clinical epidemiology to clinical practice; they reviewed over 10,000 publications and found only 346 of any worth which set the scene for future research into whiplash. Second, they established a formal definition of whiplash injury along with a system for grading the severity of the injury. Finally, they produced a set of clinical guidelines for managing the condition.

The QTF (p22S) established the following definition of whiplash injury:

Whiplash is an acceleration – deceleration mechanism of energy transfer to the neck. It may result from rear-end or side-impact motor vehicle collisions, but can also occur during driving or other mishaps. The impact may result in bony or soft-tissue injuries (whiplash injury), which in turn may lead to a variety of clinical manifestations (Whiplash – Associated Disorders).

Livingstone (2000) draws attention to the fact that the above definition does not include front-end collisions. It is not clear whether that omission was purposeful or an oversight and, therefore, it may be possible that some time in the future front-end collisions would be included in the definition. More recently Teasell and Shapiro (2002) suggest that, as well as the typical picture of the injured individual being an occupant in a stationary vehicle, the injury also frequently occurs with other types of vehicle collisions such as side-on and head-on collisions. This seems to suggest, at least theoretically, that anyone involved in a vehicular impact could sustain a whiplash injury.

An important addition to the definition of whiplash injury by the QTF was the classification or grading of whiplash injury that is linked to the presentation of symptoms. This definition is referred to as Whiplash-Associated Disorder (WAD) and is graded from 0-4 as follows:

Grade 0: No complaints of pain or physical signs.

Grade 1: Neck complaint of pain stiffness or tenderness. No physical signs.

Grade 2: Neck complaint and musculoskeletal sign(s) includes decreased range of motion and point tenderness.

Grade 3: Neck complaint and neurological sign(s) including decreased or absent deep tendon reflexes, weakness and sensory deficits.

Grade 4: Neck complaints and fracture or dislocation.

This was an important addition for two reasons. First, it allows for the actual differences between the presentations that might occur with a whiplash injury to be recognised. Secondly, the differences between the presentations could be taken into account when decisions are made as to what might be the most appropriate action to take in managing the condition. It can be seen quite clearly that psychological symptoms have not been included within this definition.

It is interesting that five years after the publication of the QTF report, a report published in 2000 by the Department of Environment Transport and the Regions (DETR) on road accidents in Great Britain continued to include whiplash injury with minor injuries that are often not considered to require medical attention. This is an important consideration for three reasons. First, it could perpetuate the notion that whiplash injury does not require medical attention when it has been established that it can be hours or days later before the symptoms from whiplash injury are experienced (Teasell and Shapiro, 2002). Second, it highlights the related issues of who makes the judgement on whether or not medical attention is required at the scene of the accident, or if and when medical attention would be required. Often it is the police officer who attends the scene of the accident or the accident victim themselves who decide that they are uninjured. As police officers are not medically trained it is neither fair nor acceptable for them to be expected to make decisions about who should or should not see a doctor. This also showed that different definitions of whiplash injury have continued to be used in the UK. With that thought in mind, I wish to make it clear at this point that I have adopted the QTF definition of whiplash injury for the purpose of this research. I have done so as this definition gives a clear statement on what constitutes whiplash injury and is able to accommodate the differences in terms of

severity of symptoms that patients might experience. Furthermore, this definition has been adopted by professionals who are experts or specialists in this area.

The QTF identified what they considered to be the main challenges posed by whiplash injury. These challenges arose out of the following findings:

- No treatment for the long duration of symptoms
- A lack of a physical explanation to account for symptoms
- Cannot explain the impact on everyday life

1.3 Psycho-social issues

Barnsley et al. (1994) in their review of whiplash injury, found that whiplash injured patients showed cognitive impairments and suggested the possibility that cognitive impairment is related to chronic pain. The issue of psychosocial factors playing a role in the development of impairments was raised in the above research, although no attempt has been made to suggest how this might happen or what these factors might be. Interestingly, when looking at muscle weakness they have this to say about attempts to convey what the difficulties might feel like to people:

...far more puzzling and more common, are subjective sensations of weakness, heaviness or fatigue in upper limbs that are unaccompanied by clear cut abnormalities on clinical examination (1994: 296).

I think this illustrates one of the difficulties faced by a biomedical framework when confronted with the subjective descriptions that are often used by people to convey what their illness means. This is because the attempts made by the patient to impart what it is like to experience their illness are not seen by doctors as being relevant to

the diagnostic process as biomedicine relies on objective evidence and technology to produce the evidence to support the patient's claims (Foss and Rothenberg, 1988; Steen and Haugli, 2000).

The symptom of pain is raised as an area of concern by professionals who work with whiplash injury and is itself an important psycho-social issue. For that reason, I introduce the discussion of psycho-social issues with the subject of pain.

1.3.1 Pain

Pain is a symptom that accompanies a myriad of conditions and has been the subject of much investigation due to the challenges that it has presented to clinicians, researchers and sufferers (Bazanger, 1992; Bendelow, 1993). Osborn (2002: 1) describes pain 'as a symptom and a condition in its own right'. The differentiation between pain as a symptom and pain as a condition is often determined by the duration of the pain experience and whether or not it is seen as part of an underlying disease process or as a psychological condition that persists after the original cause is said to have been resolved. Chronic pain is any pain that has persisted beyond a period of six months (International Association for the Study of Pain, 1986). Acute pain is what would be experienced as an immediate direct response to an injury or inflammation in the body and is experienced for less than three months in duration. Pain that persists between three and six months is said to be sub-acute. The distinction between acute and chronic pain is an important consideration as it may have implications for the management of the symptom for two reasons. Firstly, acute pain that is poorly controlled and experienced as persistent may develop into chronic pain. Secondly, the treatment of pain will often depend on the doctor's perception of the

seriousness of the symptom in relation to the condition. For example the pain from a broken bone might be perceived as requiring a stronger type of pain relief than a muscle sprain. The former may well get stronger pain relief that results in suppression of the symptom whereas the latter might be given a weaker strength that is ineffective in suppressing it. Over time the unsuppressed pain is experienced as enduring. Thus the management of pain during the acute phase might have implications for the prevention of the development of chronic pain. Thirdly, the meanings that might be ascribed to explain and understand the symptom of pain are also dependent on individual interpretation. For example, if I was pregnant and waiting for labour to start, I would take the onset of pain to mean that I was going into labour whereas if I was not pregnant I might think the pain could mean there was something seriously wrong with me.

1.3.2 Psychological trauma

The distinction between the physical and psychological experience of symptoms is an important one for clinicians when making decisions about treatment. Mayou (1995) describes how an awareness of psychologically-determined consequences of physical illness could lead to a reduction in what he defines as ‘medically unnecessary’ problems, for example depression and anxiety. Common psychological symptoms such as sleep disturbance, lack of energy and poor concentration are experienced with both physical conditions such as whiplash injury and psychological conditions such as anxiety. Radanov and Dvorak’s (1996) review of impaired cognitive functioning following whiplash injury suggest that this impairment could be from pain, medication, psychological problems or from difficulties in adjusting to trauma-related symptoms. Moreover, with patients who present with impaired cognitive function, a

comprehensive assessment was required to understand the cause of impairment. It is well established that being involved in a motor vehicle accident (MVA) can result in psychological trauma (Sterling et al., 2003; Blanchard and Hickling, 1997; Mayou et al., 1993) that can induce psychological symptoms such as sleep disturbance, lack of energy and poor concentration (Mayou and Radanov, 1996).

Radanov and Dvorak (1999) suggested impaired cognitive functioning after whiplash injury might also be due to the trauma of being in a MVA.

Travel anxiety

In 1993, Mayou et al. undertook a study to identify the psychological impact of being in a car accident. They found that the anxiety experienced from being involved in a MVA could produce a condition known as travel anxiety. This means that people with this condition can experience anxiety when they are travelling in a motor vehicle either as a passenger or as a driver. It was also suggested that if this condition went untreated or unrecognised, the level of anxiety that might be experienced when travelling could also become phobic in its intensity. Mayou et al. also found that the experience of being in a MVA could lead to changes in normal driving behaviour; for example people might become more cautious when driving, become more aware of other road users and might also exhibit avoidant behaviour. The avoidant behaviour could be as simple as avoiding the site of the accident or it could involve avoidance of travel altogether. Mayou et al. suggested that it is possible to identify those people who are likely to develop these problems soon after the initial MVA. They found that people who were still experiencing difficulties with driving associated behaviours three months after the accident were more likely to describe continuing symptoms a year later.

Ehring et al. (2006) looked at cognitive behavioural predictors to identify those who might experience psychological trauma from a MVA. Cognitive behavioural predictors were used to identify the presence of post traumatic stress disorder (PTSD), travel anxiety and depression. They found that cognitive behavioural predictors could be used to predict those who might develop psychological trauma and that each condition had its own cluster of cognitive behavioural predictors. In the case of travel anxiety, the cognitive behavioural predictors included fear during the accident; for example terrified alarm, negative beliefs related to travel, concerns about future travel and safety behaviours. Linnel and Easton (2004) looked at phobic travel anxiety and whiplash injury. They found that those who had high levels of phobic travel anxiety also reported higher levels of physical symptoms from whiplash injury. Moreover treatment aimed at alleviating the physical symptoms of whiplash injury was not effective in those patients who also had travel anxiety. It was suggested that both the physical symptoms and the travel anxiety needed to be treated concurrently. What is not clear from the studies is how or when psychological concerns should be addressed.

Post Traumatic Stress Disorder

The studies reported in the previous section on travel anxiety by Mayou et al. (1993) and Ehring et al. (2006) also showed that PTSD can be a consequence of being in a MVA. Blaiszczyński et al. (1998: 111) reviewed psychiatric morbidity following motor vehicle accidents and reported that PTSD was not a new condition:

During the 1800s the presence of persistent neurasthenic symptoms in the absence of diagnosed organic lesions following transport accidents led physicians to describe a

specific condition termed 'spinal concussion' or 'railway spine,' many features of which are similar to those described in the more recent category of PTSD.

It is interesting that the term 'railway spine' has also been interpreted by some clinicians as 'whiplash injury' (Burton, personal communication). This is important as PTSD has been more generally considered an outcome of more catastrophic events such as war and rape (Cascardi and O'Leary, 1992; Scurfield, 1993; Turnbull, 1998).

Blaiszczyński et al. (1998) raised the issue of blame in that those participants who felt they were not responsible for their predicament were more likely to report long term distress and loss of confidence in driving ability. The participants who were responsible for their own accidents were found to use, what they describe as, more self-blame coping than those participants who were not responsible for their accident. Self-blame coping means that it was their own fault and suggests that one might have more control to prevent a similar situation arising in the future. A person with whiplash injury is generally associated with not being the cause of the car accident and this might also be a useful way to understand why people with whiplash injury might experience PTSD. An awareness of how people feel about their accident might have treatment implications.

1.4 Thesis outline

In order to guide the reader through this thesis I will now go on to outline the structure and content of the remainder of this thesis.

Chapter two looks in depth at the value and use of alternative models that try to understand what it means to have a whiplash injury. The argument for attending to the personal meaning of whiplash injury is developed.

Chapter three explores the philosophical assumptions underpinning the research and the methodological approach that I have taken in this research. This is followed by an explanation of the research process that was undertaken to carry it out.

Chapter four discusses the method used with patient participants and the rationale for my presentation of the findings. Individual case studies of their experience of whiplash injury are presented.

Chapter five presents the patients' case studies and individual experiences.

Chapter six presents the cross case analysis of the full patient data set, (using a template approach). The psycho-social effects of whiplash injury are discussed and the identification of potential implications of the injury for healthcare provision from the patient's perspective is highlighted.

Chapter seven goes on to describe the method used with doctor participants and my reflections on the difficulties I experienced whilst carrying out the data analysis.

Chapter eight presents a cross case template analysis of their understanding of what a whiplash injury meant to them and how they treated their own patients.

Chapter nine is the discussion chapter and consists of three parts as it brings together the findings from the patients' and doctors' accounts of whiplash injury. These are: the psycho-social experience of whiplash injury, doctors' approaches to whiplash injury, implications for patient experience and trust.

Chapter ten concludes with a discussion of the occupational implications of whiplash injury, the allocation of resources and the potential implications for policy and practice before going on to describe my personal reflections on carrying out this research and make recommendations for future research.

Chapter Two: Understanding the Experience of Whiplash Injury

In chapter one it was shown how the Quebec Task Force (QTF) raised two main areas of concern about whiplash injury that the medical model was unable to account for. First was the long duration of inexplicable symptoms and second was the impact on everyday life. The lack of an adequate explanation to account for people's experience of whiplash injury has led the injury to be seen as controversial (Barnsley et al., 1994; Waddell et al., 2002) and as a ruse for obtaining compensation. The identification of these concerns by the QTF has led to the application of different approaches to understanding whiplash injury and its psycho-social consequences.

In this chapter, I will begin by exploring a societal account of compensation, before I go on to look at the biopsychosocial perspective and finish with the psychological approaches. The QTF report highlighted the failure of biomedicine to either 'cure' or provide an understanding of whiplash injury that could also explain the psycho-social aspects that many patients experienced. These aspects are: chronic pain, cognitive impairment such as forgetfulness, poor concentration, and sleeplessness, and the effect of the loss of mobility, reported by people who had experienced a whiplash injury. The newer approaches have also been criticised for failing to take account of the subjective experience and personal meaning of illness (Kugelmann, 2004; Osborn, 2002). After exploring the different understandings of whiplash injury and associated psycho-social aspects; I will go on to conclude this chapter by suggesting the adoption of a critical health psychology stance, and in particular a phenomenological approach, towards the understanding of whiplash injury, and will end with a statement of the aims of this study.

2.1. Compensation

The issues discussed so far have shown that whiplash injury has continued to remain in some respects an enigma for the medical model. This enigma has led to the medical model drawing on the issue of compensation to try and account for the long duration of inexplicable symptoms and the impact on everyday life. The issue of compensation is both controversial and important as it has implications for the way the patient's experience might be understood.

The fact that people continue to complain of problems such as pain from whiplash injury months or years after the accident, is related to the idea of secondary gain and the notion of compensation. Secondary gain as a concept has been ascribed to the work of Freud (Fishbain et al., 1995) and is associated with two types of 'gains' from illness. Primary gain is when anxiety from an emotional conflict is converted into an illness. Freud (1959) defined secondary gain as 'interpersonal or social advantage attained by the patient as a consequence of his/her illness' (Fishbain et al., 1995). This gain is said to be acceptable or legitimate, as in the conferring of the sick role which legitimates a person's right to withdraw from their usual occupational role (Parsons, 1964). Fishbain et al. (1995) suggest that the existence of this role introduces an important variable into the realm of illness behaviour in as much as it might motivate people either consciously or unconsciously to seek out this role as a means of escape. The sick role may have, or lead to, secondary gains for the patient (Mechanic and Volkart, 1960).

Mendelson (1992: 1212) drew attention to the first reported case of an employee seeking compensation for pain. This took place at the High Court in England in 1837,

showing that claiming compensation for pain and injury is not new. The original verdict in this case was to award £100 compensation in favour of the plaintiff. This decision was subsequently overturned on appeal by Lord Abinger who noted 'if the master be liable to the servant in this action, the principle of that liability will be found to carry us to an alarming extent' (Priestly v Fowler 1837). The floodgates would have been opened for all those who were injured during the course of their work. Sixty years later, in 1897, the introduction of the Workman's Compensation Act and a statutory scheme to provide income to those workers who had been injured at work on a no fault basis came into existence (Bartrip and Burman, 1983). This act appeared to be influential for the development of the notion of malingering. Collie (1932: 1) stated:

Fraud is a product of the age, of the Workmen's Compensation Act, of Trade Unions and allied Clubs. There are no malingerers in countries where there is no Workman's Compensation Act.

The notion of malingering was seen as being relevant to the experience of pain as it is a subjective experience and open to interpretation (Slot, 1927). This also makes a strong suggestion of cultural influence on the idea of malingering. According to Collie (1932: 32);

In dealing with back injuries it is necessary to make up one's mind on two points. First, is the pain real, psychic or assumed: second, is it due to disease or accident? In the vast majority of cases alleged pain in the back is mental and not physical.

It is easy to see why the explanation of compensation and malingering might be used to explain why people might continue to complain of problems such as pain from whiplash injury months or years after the accident when the validity of the patient's complaint of symptoms, and by default their injury, is questioned from the beginning.

Malingering is the idea that symptoms one might experience are exaggerated or fabricated in order to gain something. In the case of compensation, the gain is monetary. This might also explain why receiving compensation is also suggested as being a reason why some patients were seen to have made a recovery after the case is settled (Schofferman and Wasserman, 1994; Gotten, 1956). The presumption of the idea of gaining financial remuneration for the pain-related injury is thought to encourage functional impairment and inhibit recovery from the injury (Wallis et al, 2003).

Swartzman et al. (1996) looked at the effect of litigation status on adjustment to whiplash injury. They suggested that the assumption made about financial gain from compensation is based on anecdotal or single case evidence. They found that the professional's use of anecdotal evidence was particularly relevant to patients who lacked identifiable physical causes for their pain. The anecdotal evidence allowed the doctors to arrive at the judgement that these patients' complaints were being used by them as means of gaining financially through the fabrication or exaggeration of their symptoms. This idea was most noticeable for patients who were seen with whiplash injury and this is embodied in their use of the following quote that they ascribe to Miller (1961):

...a compensation neurosis is a state of mind born out of fear, kept alive by avarice, stimulated by lawyers and cured by verdict. (p53)

The online medical dictionary (Medilexicon, 2009) defines compensation neurosis as the development of symptoms of neurosis that is motivated by the desire for, and hope of, monetary or interpersonal gain. Swartzman et al. found that litigation status did not predict employment status and suggested that secondary gain was not a major

influence on the patient's recovery from whiplash. They did find that litigants reported more pain than non litigants, but they suggest that this may be due to whiplash patients having a greater need, than patients who have a broken limb, to communicate the extent of their pain. They highlight the fact that reporting more pain is not the same as malingering. They also found that completion of the claim did not mean that the pain from the whiplash injury resolved completely.

Schofferman and Wasserman (1994) found that patients who had a readily identifiable structural source for their pain were taken seriously by the medical and legal communities. In contrast to this, they found those patients whose cause of pain was considered to come from a soft tissue injury and diagnosed with a sprain or strain were looked on disparagingly by the same medical and legal communities. These patients were also more likely to be considered to have 'accident neurosis'. This is a term used to mean a functional nervous disorder such as post traumatic stress disorder following an accident or injury. They conducted a prospective study that looked at the outcome of treatment given to patients with low back pain or neck pain whilst they were pursuing a claim for compensation. None of the patients in the study had their compensation claim settled before treatment was completed. They found that the patients showed significant improvement with treatment even though their compensation claim had not been settled.

Paramar and Raymakers (1993), in their review of claimants seeking compensation for whiplash injury, found that the timing of compensation was not associated with an improvement in symptoms. They also found that the earlier a person experienced the onset of pain following the whiplash injury the worse the level of pain was found to

be at the review. This is an interesting point as it appears to suggest that early onset of pain might be a potential indicator of the severity of the injury and chronicity. The patient is not exaggerating their symptoms so they can pursue a claim for compensation. They pursue the claim because of the problems experienced from the whiplash injury.

Schmand et al. (1998) also looked at the issue of malingering with chronic whiplash injury. They administered a newly developed tool known as The Amsterdam Short Term Memory (ASTM) test to two groups of patients. One group was examined as part of the litigation procedure and the other group was seen as normal routine outpatients. They found that there was some support for the notion that some people who presented with cognitive complaints were malingering. However, they also found that a significant number of those participants in the study who were identified as non-malingering also showed cognitive complaints. They came to the conclusion that the problems that patients experienced post whiplash injury were not imaginary products, but recognised that a small number of patients might use the whiplash injury to gain financially. Guest and Drummond (1990) made the point that the adversarial nature of claiming compensation is also a source of emotional distress for many people. Shapiro and Roth (1993) also acknowledged the emotional strain that accompanied the legal proceedings and go on to suggest that this might have a subsequent impact on the patient's pain and coping. They also make the point that it would be 'naïve to assume that litigation has no effect' and that the myth of 'compensation neurosis' persists because of reasons related to physicians' frustrations in treating difficult patients with chronic pain and dualistic notions of pain being either 'physical or psychological' This points towards a problem in practice. Given

what we know about the way labelling impacts on the way patients are seen (Scambler and Hopkins, 1986; Goffman, 1990; Taylor, 2001) one might assume that malingering and neurosis have different meanings and connotations.

Cassidy et al. (2000) looked at the incidence and prognosis of whiplash injury following a change from the tort-compensation system for traffic injuries which included payment for pain and suffering to a no fault system which did not include payment for pain and suffering in Saskatchewan Canada. They found that the elimination of compensation for pain and suffering was associated with a decreased incidence and improved prognosis of whiplash injury. They also found that patients who claimed under the no fault system recovered more quickly than in the tort system. The Saskatchewan health care programme is universal and there are no barriers to care suggests that those patients whose injury is more severe automatically receive any physical treatment that might be required. This is different to the NHS where physical treatments are not as readily available. This study also showed that other factors such as initial care, initial intensity of pain and level of physical functioning were implicated in a protracted recovery.

The above issues have revealed the complexity of the impact of whiplash injury and how alternative explanations to the medical model are sought to provide a satisfactory account. This situation is unsatisfactory for all those concerned with whiplash injury, whether they are a patient or healthcare professional. Waddell (1987: 638) stated:

Human beings dislike uncertainty, fear the unknown, and search for meaning as the first stage to control.

This failure has led to health professionals from a wide range of disciplines to become dissatisfied with the constraints of the medical model when trying to account for the complexities of their patient's condition. This state has resulted in the search for a more comprehensive model that could provide a rationale for their patient's condition.

2.2 The need for an integrated approach

The idea that a more integrated approach is required to understand illness is not a new one. During the 1970s one professional who became disillusioned with the medical model was Engel. He was a psychiatrist who found the medical model did not provide him with a satisfactory means of understanding the experiences and problems that were faced by his patients. Engel (1977) developed a social model of health that used a systems approach to conceptualise the person, the family, the community and the culture as a way of being able to understand and respond to the patient's suffering. The three components of the model are the biological or body, psychological and social factors. This meant illness was recognised as affecting the person psychologically and socially as opposed to just seeing the illness in terms of its biological or physical effect. It might be argued that this is a more holistic way of seeing the person and their illness and this differs quite markedly from the medical approach.

I think it is important to bear in mind what is meant by the term holistic and the various ways it can be interpreted. When I look back on my own professional experience and training as a nurse and health visitor I became aware that there were differences in the way the term holistic can be understood. For example, as a nurse the

holistic approach meant that the patient was more than the disease, they also had psychological and spiritual needs to be attended to. This meant the patient was no longer to be seen as just the condition, for example, ‘the appendicectomy in bed 3’; they had to be seen as a person who was affected by the condition they had. This was still a very individualistic way of seeing the person and the social world of the patient was not really part of the picture. When I became a health visitor my understanding of what holistic meant changed again with the adoption of a social model of health that took into account other interrelated aspects of life such as culture, work, and relationships. My understanding of holistic has changed from an individualistic view into a view that also includes the personal and the social. The application and understanding of the term holistic is an important one as it provides clues to the context or background that are used by professionals to understand their patient’s experience. Engel’s approach to understanding disease paved the way for the development of the biopsychosocial perspective.

2.2.1 The biopsychosocial perspective

One problem I have found in the literature that can be confusing when discussing the biopsychosocial model comes from the way in which this has also been referred to as a biopsychosocial approach or a biopsychosocial perspective. To overcome this I will use the term biopsychosocial perspective at all times within this thesis. This is because using the term perspective means a particular way to look at something.

The clinicians Waddell (1987) and Turk (1983) were influential in the development of this perspective in general and its application in improving the understanding of chronic pain and musculoskeletal disorders such as lower back problems. Waddell

(1987) an orthopaedic surgeon, in his work with musculoskeletal problems, used the biopsychosocial perspective to try and account for the experience of chronic lower back pain that his patients experienced in the absence of physical factors to account for their problems. Waddell outlined the areas of pain, attitudes and beliefs, psychological distress, illness behaviour and social environment as being the framework for understanding many of the clinical observations that could be made with musculoskeletal conditions.

Turk (1996:6) working in the field of chronic pain defined the biopsychosocial perspective and its focus on illness as the:

...result of a complex interaction of biological, psychological and social variables. The diversity in illness expression (which includes its severity, duration and consequences for the individual) is accounted for by the interrelationships among biological changes, psychological status and the social and cultural contexts that shape the patient's perception and response to illness.

This meant that each individual person was seen as having predisposing, precipitating and maintaining biological and psycho-social factors that interacted to produce and maintain chronic pain and disability. The biopsychosocial perspective allowed understanding of the dynamic nature of chronic conditions. In practice, though, it maintains and reinforces a reductionist system (Dean, 1998).

Turk (1996:6) emphasised the importance of the biopsychosocial perspective's focus on illness instead of disease. By taking this perspective, it could account for the differing experiences of illness people have. Turk pointed out that in chronic conditions the individual expressions of symptoms, distress and disability are loosely related to the observable pathology. Whilst biological factors are seen to initiate,

maintain and modulate physical sensations, psychological factors influence the perceptions and interpretations of those physical sensations and social factors influence the behavioural responses that are made to the physical sensations. From this perspective, pain is understood as ‘a subjective perceptual event that is not solely dependent on the extent of tissue damage or organic dysfunction’. The experience of pain is affected by a range of factors such as the meaning of the situation, mood, cultural background, social supports and financial resources. Treatment based on the biopsychosocial perspective as applied to chronic pain must also address the range of factors that are known to affect pain, disability and distress. This means that treatments are designed to change the patient’s behaviours even if the pain is not controlled. This is achieved by providing the patient with a repertoire of techniques that are aimed at gaining control of the effects of pain on their life.

The psychological component in this perspective as applied to musculoskeletal conditions draws heavily on the notion of fear-avoidance. In the context of acute injury, this avoidance of movements and activities that might make the situation worse is seen as adaptive behaviour as it allows healing of the tissues to take place (Wall, 1979) whereas in chronic pain the avoidance of movements and activities is seen as being maladaptive. The fear avoidance concept is based on the work of Philips (1974) and was used to account for the experience of chronic pain. He proposed that pain comprised physiological, subjective and behavioural dimensions. Whilst these dimensions are inter-related, it is also possible that under certain conditions they ‘desynchronise’.

Hill (1998: 159) used a commonly found situation in patients with chronic pain to provide an example of how this is seen to work. This idea was demonstrated using two categories of patients. The two categories were (1) severe pain with minimal fear of pain attached to the experience and (2) severe pain with a strong fear of pain. Those patients who were seen to attach minimal fear of pain were able to confront instead of avoid painful experiences. This was seen to result in 'coping wellness'. Those patients who were seen to attach strong fear of pain avoided painful experiences. This was seen to result in 'chronic pain disability'.

This works by allowing the psychological or affective dimension to become dominant in a multidimensional construct model of pain instead of a single construct model of pain. The research into low back pain has suggested that it is the patient's fear of making their situation worse that leads them to the avoidance of certain movements and situations (Waddell, 1987; Valeyán and Linton, 2000).

Studies such as this research have led to the legitimization of the biopsychosocial perspective as a credible alternative to the medical model. This is because this perspective is able to provide an understanding of inexplicable symptoms that patients might present with (Main et al., 2000). Cooper et al. (1996: 2) have also suggested that this perspective owed its acceptance amongst academics and practitioners alike to being seen as integrative and giving a holistic understanding of health and illness. More recently Burton et al. (2008: 18) suggest that this acceptance might also be due to the predominance of pain as a symptom in musculoskeletal conditions and 'that for this reason there has been something of a conversion between the fields of musculoskeletal medicine and pain management'. Moreover, Waddell and Burton

(2002) suggest that the understanding of chronic health problems and disability can only be understood and managed through the use of biopsychosocial perspective.

Freeman and Russell (1999) suggested that the adoption of the biopsychosocial perspective was necessary to move away from the medical model in relation to understanding whiplash injury. This appears to be significant given the fact that in chapter one it was seen that whiplash injury was not a disease but a definition of an injury and may well reflect a response to the Quebec Task Force's call to address the challenge posed by whiplash injury. Freeman and Russell proposed that people with whiplash injury and low back pain have much in common. The common ground between the two conditions stemmed from the sufferer's fear of making their symptoms worse. They also suggested that in some Western cultures such as America and the United Kingdom psychological, social or cultural factors have created an expectation that they will experience pain and therefore they become hyper-vigilant for symptoms from a whiplash injury. This is seen as being a factor in promoting what they term as symptom amplification. That is, the patient perceives the symptoms as being more severe or serious than they are seen to be from a biomedical perspective. This appears to be similar to the way the symptoms are seen as being disproportionate to the injury within the medical model. Freeman and Russell draw on the psychological and social component of the biopsychosocial perspective to support their call to use this way of accounting for the long duration of inexplicable symptoms. The adoption of the biosychosocial perspective to understand many chronic illnesses appears to be one of the influences that has led to a change in the way society has come to view sickness absence.

Societal change towards sickness absence

The last decade has seen an increase in focus on the number of people who suffer from a chronic condition that has often resulted in them being excluded from work (Waddell and Burton, 2006). In response to this finding the government commissioned Black (2008) to undertake a review into the health of Britain's working population. This review has paved the way for reaching changes on the way sickness absence is viewed, with the aim of reducing sickness absence and keeping people in work. At the heart of these reforms lies the belief that work is good for people's physical and mental health and well being (Waddell and Burton, 2006; Seymour & Grove 2005). Waddell and Burton's (2006) review of the literature was commissioned by the Department of Work and Pensions in order to answer the question, 'Is work good for your health and wellbeing?' They came to the conclusion that not being in work was associated with poorer physical and mental health and wellbeing. This led them to propose that work was therapeutic and could reverse the deleterious health effects of unemployment. More importantly this was found to be the case for healthy people of working age, for many disabled people and for most people with common health problems, as well as those on social security benefits. In other words very few people were seen to be better off out of work than in work. The overall beneficial effects of work were seen as outweighing the risks that could be associated with it.

Cox et al (2004) looked at employment and mental health. They identified a dynamic relationship between work and health and that this relationship could be used to protect and promote health. Whilst they recognised that work on the one hand could create or aggravate mental ill health, they also found that for those people who were out of work involuntarily or returning to and remaining in work could improve their

mental health and suggest that being in work could be therapeutic. For those people out of work, mental ill health was also seen to get in the way of them returning to or staying in work.

Dodu's (2005) review of the literature suggests that employment is important for individual well being as it provides the individual with financial gains, social identity and status, a sense of personal achievement and a way of structuring time. However, while work is seen as being important for well being, work is also seen to pose a wide range of potential occupational risks and psychological risks to health. The extent to which work is good for well being is dependent on the individual's situation. For example, being out of work might create feelings of worthlessness or anxiety due to loss of income or a person in work may feel under pressure if there has been a reduction in the number of people in a team without a reduction in workload to compensate. That same person might find that a physical problem such as a hernia might become more problematic if they have to stand up for longer periods of time. This brings the challenge of how to assess these complexities.

These findings show that work is only beneficial in some circumstances. For the majority of people, being out of work is a risk although for some people being in work is also a risk. This can also be seen in people with musculoskeletal conditions where some disorders, such as cramp of the hand or forearm due to repetitive strain, are considered to be one of the prescribed industrial injuries (Industrial Injuries Advisory Council 2006). With repetitive strain injury it is recognised that going back to work doesn't help. In whiplash injury which isn't a proscribed injury people don't recognise that going back to work won't help you but it will make it worse and a whiplash injury could reasonably be seen as similar in this respect. One of the

challenges that the doctor might face here is concerned with how to assess the complexity of the situation. By looking at the person holistically and by looking at lived experience you see complexity in living with whiplash injury and other conditions that might otherwise be overlooked.

A key change that doctors, and general practitioners in particular, face comes from the introduction in April 2010 of a requirement to certify people as fit to work. This contrasts with the old system whereby a sick note meant exclusion from work. The new emphasis on fitness to work means that a person who might not be able to carry out a specific part of their role at work could be expected to continue working. These changes, by necessity, involve new ways of looking at old problems. Waddell and Burton (2004) looked at a range of chronic conditions in relation to rehabilitation and work. They made a distinction between severe health problems such as blindness and neurological problems and what they term as 'less severe health problems' such as musculoskeletal, some cardio-respiratory problems and less severe mental health that they refer to as 'common health problems' that cause incapacity. More manageable problems that are in these categories need not prevent you from going back to work. An example would be where a person who has had a heart attack is not automatically excluded from returning to work. Waddell and Burton (2004:11) refer to common health problems specifically as 'subjective health complaints' that have symptoms that are medically unexplainable and have little or no evidence of objective disease or impairment. Whilst people with these complaints are also seen to have 'more symptoms and distress' it does not mean that long term incapacity is inevitable. Whiplash injury is regarded as a common health problem and, for that reason, it is

important that doctors and others who work with this injury need to be aware of the occupational difficulties that can be experienced with this injury.

Understanding how and in what way occupational limitations are experienced by people is important when developing interventions that are aimed at the utilisation of the biopsychosocial perspective. Waddell et al. (2002) developed a booklet entitled *The Whiplash Book* to promote better handling of whiplash injuries. They promote the biopsychosocial perspective and their message is that whiplash injury is not a serious condition, although it can be painful, and you should not become disabled unless you let the whiplash injury stop you from doing things. Whilst this message is generally helpful there are potential problems in the way any consequences from the injury are framed psychologically.

The first issue arising from this message is the suggestion that the patient is somehow able to exercise a conscious decision on whether or not they become disabled by the whiplash injury. This points towards a moral issue that is based around the notion of autonomy and this is particularly relevant for western societies (Marks et al., 2005). If the patient becomes disabled they are held responsible for their actual physical limitations and a judgment is made as to whether or not they have fulfilled their obligation to make themselves better. If the patient does not get better, it is because they have abdicated their responsibility in looking after their self; for example, in ignoring any advice they might have been given regarding maintaining movements, they have not fulfilled their moral obligation. Also this might be seen as the patient lacking in motivation.

The second issue is concerned with the concept and meaning of disability and might have implications for how the sufferer might change their view of self. The sufferer is framed as either a 'coper' or 'avoider' and suggests that people fit into one of the categories. The use of two categories such as 'either' and 'or' by main stream health psychologists has come under much criticism as it fails to show how individuals vary in their responses to and perceptions of pain (Horn and Munafò, 1997) or stress (Bartlett, 1998). The categorisation of 'coper' or 'avoider' is a professionally determined appraisal of how an individual is seen to manage and respond to illness which, in this case, is whiplash injury and does not take into account differences in how the individual appraises their situation or even their particular coping style.

The sufferer, who based on their own appraisal of the situation avoids activity, is identified as 'the avoider' and the one whose appraisal enables them to carry out activity is identified as 'the coper'. Looking at people in terms of 'coper' or 'non coper' is quite simplistic and also problematic as it suggests that people are fixed in one style of coping and that there is a right and a wrong way to manage (Radley, 1994), when what they actually do is find ways that suit their individual needs and lifestyles so they can get on with the business of living their lives.

Moos and Schaefer (1984) identified three forms of coping skills that people use to manage physical illness. These are:

- Appraisal-focused: involves logical analysis and mental preparation, cognitive redefinition and cognitive avoidance or denial.
- Problem-focused: taking problem solving action, seeking information and identifying rewards.

- Emotion-focused: affective regulation, emotional discharge and resigned acceptance.

In contrast to the idea of ‘coper’ versus ‘non-coper’ this research shows that the styles people use to manage their illness are much more complex when people suffer from a chronic illness and what might be considered as ‘giving up’ may well be a better way to deal with the problem. King et al. (2002) showed that people with diabetic renal disease adopted a variety of coping styles that included ‘control seeking, denial, optimism, defeatism and stoicism’. The research suggests that it is styles rather than types that are important for understanding how people manage chronic illness.

To be seen as not coping might also affect the patient’s self esteem as they lose the ability to carry out everyday activities. They are also put into a position of not knowing if and when they will regain self control as the biopsychosocial perspective, like the medical model, is unable to account for the impact on everyday life. The role of self esteem is also an important part in the coping process (Meijer et al., 2002) as it helps in the development of an illusion instead of a reality orientation (Ogden, 2004). Also this view might have an effect on the person’s self concept and the way in which they see the effect of being described as an ‘avoider’ or ‘non coper’ might have and how that might change their sense of agency or self control.

The emphasis throughout is on self management and staying active which is in keeping with maintaining patient autonomy. There is a useful and informative section in the booklet on treatment and management of whiplash injury but I found it strange that a fully mobile neck was not seen as being necessary to carry out all normal activities. I think that this omission has serious consequences for the understanding of

the impact of whiplash on everyday life and how that might be perceived as disabling and disruptive for the patient. Whilst not devaluing their approach in providing patients with authoritative information about whiplash injury, the psychology that informs the messages in the book draws on what can be considered as the use of positive thinking; for example, the patient needs to think, or believe, that their injury will get better even if that is not the case. As noted earlier this aspect has a moral quality as the patient is seen to be responsible for their predicament. Waddell et al. have also failed to identify or account for any psychological problems such as travel anxiety. This seems to be a strange omission given the emphasis that is placed on the psychological component in its application to whiplash injury. One reason for this might be due to the way in which the perspective appears to work mechanistically and has been focused on the long duration of inexplicable physical symptoms instead of when the symptoms first occur. The psychological component is used when the physical component is not able to provide answers. Each part of the model then offers a different level of understanding. In that sense, the biopsychosocial perspective can be seen as reductionist and, in common with the medical model, it is concerned with parts and not wholes (Forster and Stevenson, 1996).

Cooper et al. (1996: 4) identified a problem with the way the biopsychosocial perspective has been interpreted and understood by those people who have adopted this model. Far from it being an integrative model that sees the biological, psychological and social perspectives as being complementary, these perspectives can often be interpreted as multiple rather than integrative. The multiple interpretation leads back to a mechanistic way of viewing the perspectives as components that fit together rather like the medical model instead of providing 'plausible explanations of

the interrelationships between these factors'. The emphasis on one part of the model having more importance than others at any given time is more suggestive of an eclectic approach. Eclectic is a term widely used within counselling and psychotherapy and means to select or use what is best from various systems. The lack of physical factors to explain the disease results in the predominance of other parts of the model, for example psychological, to become predominant in producing explanations by allowing a range of psychological factors to be examined. There is also a notable absence of the subjective aspect of experience from the psychological part of this perspective as 'subjective phenomenon and any discussion and any internal mental objects... [is seen as] meaningless and irrelevant' (Horn and Munafò, 1997:2).

Whilst this perspective has failed to offer any explanation about the impact of whiplash injury for everyday life it has been beneficial to the discipline of psychology as it enabled the emergence of psychological approaches to understanding illness. According to Crossley (2000: 4) the role of 'mainstream' health psychology in understanding illness has grown out of the biopsychosocial perspective and, like biomedicine, has used traditional scientific methods. This means that there has been a reliance on pre-defined models of health - and illness - related behaviours that use quantitative methods to examine relationships between variables such as fear and avoidance. A major advantage to this approach is related to the way it has been accepted by medical clinicians and researchers who are familiar with the language of scientific investigation (Yardley, 1997). The turn towards behaviours as a way of understanding chronic illness also led to a focus on the doctor-patient relationship to try and identify those characteristics that might be implicated in the way patients

respond to the doctor's management of their condition. This was seen to be particularly important for understanding why patients may or may not take their medication (Marks et al., 2005; Yardley et al., 2001).

2.3 Psychological approaches to understanding illness

Various psychological models such as the health belief model (HBM) and the cognitive behavioural model have been developed by health psychologists to assist with the understanding of chronic illness and the prediction of health behaviours that might help in the prevention of chronic disease in the first place (Ogden, 1996). The HBM was developed to understand and predict health behaviours. The development of the cognitive behavioural model (CBM), or cognitive behavioural theory as it is more commonly known, was instrumental in revolutionizing the treatment of many chronic health conditions. This has been achieved through the development and application of a treatment known as cognitive behavioural therapy (CBT). This has led to the predominance of CBT within the National Institute for Health and Clinical Excellence (NICE) guidelines as the preferred treatment strategy for a diverse range of medical conditions such as chronic pain, chronic fatigue syndrome, irritable bowel syndrome, anxiety and depression.

2.3.1 Health belief model

The HBM was developed to understand and predict health behaviours that might help in the prevention of disease and to help in identifying behavioural responses by patients to acute and chronic illness (Rosenstock, 1966; Maiman and Becker, 1974; Becker et al., 1977). This model suggested the importance of understanding people's core beliefs about illness and behaviour in predicting people's responses and

readiness for behavioural change. A good example of this is the smoking cessation programme. According to the HBM, behaviour is the result of a set of core beliefs that become redefined over many years. The original core beliefs are related to the individual's perception of their:

- Susceptibility: to illness (e.g. 'my chances of getting lung cancer are high');
- Severity: of the illness (e.g. 'lung cancer is a serious illness');
- Costs: involved in carrying out the behaviour (e.g. stopping smoking will make me irritable');
- Benefits: involved in carrying out the behaviour (e.g. stopping smoking will save me money');
- Cues: can be internal (e.g. the symptom of breathlessness), or external (e.g. information in the form of health education leaflets);
- Diverse factors: demographic, ethnic, social and personality.

Further development of the HBM can be seen in the social cognitions model that also includes factors such as self esteem and autonomy.

2.3.2 Cognitive behavioural theory

Gatchell and Turk (1999) identified the importance of psychological theories in understanding the development and maintenance of pain. They defined four important milestones in the development of these theories. These points were, Melzack and Wall (1965) gate control theory of pain, the work of Miller (1969) and Basmajian (1963) demonstrating how psychological factors could influence physiological activity in the muscular and vascular systems and Fordyce's (1976) work on the role of learning and conditioning factors in communication and pain behaviour. Fourthly, the work of

Turk et al. (1983) integrated the above findings into a cognitive – behavioural model of chronic pain and its treatment. These findings have also been important because of the transferability and utility to a wide range of medical conditions. This approach paved the way for a cognitive behavioural approach to understanding musculoskeletal conditions. More importantly, this approach has no reliance on a physical basis for the experiencing of symptoms.

The cognitive theorists focus on the individual's appraisal of their situation and the way in which they make sense of their experience. They emphasise the importance of the individual's beliefs and the effect that this has on their behaviour. Drawing on these theories, the cognitive behavioural model focuses on the beliefs that are held by people about their condition. The cognitions, that is beliefs or thoughts that people have about an experience, are linked to their feelings, behaviour and physiology. Osborn (2002: 30) suggested that people's understandings and beliefs about their illness have implications for their illness experience and their behaviours and treatment. Furthermore, the type of beliefs that the person holds towards the onset of their condition will influence their attitude towards it. If people are able to find a reason for their condition such as an event, like an accident or illness, they are more likely to be able to make adjustments than if there was no underlying event to account for their experience as is often the case with chronic pain (Toomey et al., 1997; Turk et al., 1996).

Fear Avoidance

This important concept was discussed earlier (see page 41). In relation to the biopsychosocial perspective it plays a major role in understanding the development

and maintenance of chronic pain. Asmundson et al. (1999) in their review of the role of fear and avoidance in chronicity, highlight how the combination of fear of pain, fear of pain-related experiences and avoidance behaviour might be more disabling than the pain. Patients with pain were also seen to be fearful of a variety of situations that were not connected to the pain. Asmundson et al. also suggested that attentional processes might influence the intensity of the pain experience. Crombez et al. (1999) looked at the interrelationship between attention to pain and fear. They claimed that pain functions by demanding attention and that this results in a reduced ability to focus on other activities. They suggested that pain related fear increased the amount of attentional interference and that this led to the creation of hypervigilance towards the pain. The effect of the hypervigilance was seen to contribute towards the development of chronic pain.

Catastrophizing

Catastrophizing has been shown to play a role in many medical conditions (Turk et al., 1983; Burns, 2000; Crombez et al., 2003). Keefe et al. (2000) described catastrophizing as consisting of three components. These are:

- Rumination which is a focus on threatening information; this can be either an internal or external source for example 'I can feel my neck clicking'.
- Magnification or overestimating the extent of the threat for example 'the bones are crumbling'.
- Helplessness or underestimating resources both personal and other resources that might help to lessen the danger and disastrous consequences for example nothing can be done.

The cognitive behavioural model differs from the medical and biopsychosocial perspective in that it is focused solely on psychological processes to explain the symptoms and achieve therapeutic interventions and outcomes (Osborn, 2002). The increased value placed on the use of the cognitive behavioural model of pain by multidisciplinary teams in pain clinics has led to the adoption of its application as a model by many clinicians who treat musculoskeletal disorders (Turk et al., 1983; Keefe et al., 2000; Waddell and Burton, 2004).

2.3.3 Cognitive Behavioural interventions in chronic illness

This model has also informed the development of the cognitive behavioural therapy (CBT) approach to treating chronic pain (Turk et al., 1983). More recently, the National Institute for Clinical Excellence (NICE) has endorsed CBT as the preferred treatment choice for a range of mental health conditions such as mild depression, anxiety and eating disorders (Simos, 2002; Williams, 2006) as its focus is on changing people's cognitions or thoughts and behaviours without having to take into account emotional or physical feelings (Beck, 1976). This is achieved by identifying the trigger[s] or antecedent[s], behaviour[s] and consequence[s] and uses a range of techniques or strategies to achieve the desired change (Beck et al., 1979; Kuehlwein, 2002). The development of the cognitive behavioural model for understanding chronic illness has been particularly significant for physiotherapists who work with musculoskeletal conditions and whiplash injury in particular (Gifford, 2006). This has been demonstrated by the Physiotherapy Pain Association's (PPA) move away from the biopsychosocial assessment that was used to underpin their understanding and treatment of whiplash injury and musculoskeletal conditions (PPA, 1998; PPA,2000)

to the use of the cognitive behavioural approach to understanding and managing musculoskeletal disorders in the context of the 21st century (PPA, 2006).

As noted earlier, cognitive behavioural interventions have been widely embraced by healthcare providers and purchasers as the preferred intervention for a range of conditions. Anecdotally, this approach is being criticised within the psychotherapeutic community because of its lack of holism and evidence to support the claims made about its efficacy. This approach has also been criticised within the literature on chronic pain (Horn and Munafò 1997; Osborn, 2002) for focussing on pain management, as this reduces the experience to a set of variables that can be manipulated to achieve the desired outcome. For example, pacing that means increasing or decreasing the level of activity that might be carried out to maintain functioning or the use of distraction techniques to control the pain.

Osborn (2002) suggested that living with chronic pain is not just about managing the sensation and unpleasantness of the pain experience. It is also about the personal and social impact that accompanies the changes that are brought about by the uncertainty and the losses that it brings to the sufferer and their relationships in everyday life (Main and Spanswick, 2000).

To go back to the two concerns highlighted at the beginning of this chapter, it can be seen that the cognitive behavioural model can provide an explanation for the long duration of symptoms in terms of psychological factors only and is reductionist rather than holistic. This approach means that there is no need to attend to the physicality of

the injury and neither can it tell us anything about the impact of whiplash injury on everyday life.

It could be argued that the psycho-social issues identified and discussed so far could be described as arising out of and having importance and meaning for the clinical perspective of whiplash injury but reflect neither the meaning nor importance of psycho-social issues from the patient's point of view. I am going to suggest that the biopsychosocial perspective and cognitive behavioural approach to understanding whiplash injury, whilst providing further illumination about the condition, fail to take into account the subjective experience of what it means to suffer with illness and the implications that might have for management of whiplash injury during the 'acute' phase of the injury. This suggestion is in keeping with the criticism that has been made from a critical health psychology perspective towards the biopsychosocial model and mainstream psychological theorists who have been instrumental in the development of the cognitive behavioural model. The reason behind this criticism is the reduction of psychological explanations into objective quantifiable data that help uncover 'the truth' about health and illness, and at the same time the subjective or personal experience is disregarded (Crossley, 2000).

2.4 Towards a phenomenology of whiplash injury

Looking at the patient's subjective experience of what it means to have a whiplash injury is important as it opens up the possibility of that experience being used to increase our understanding beyond the biomedical explanation. According to Helman (1981: 551) looking beyond the medical explanation of disease is important for "medical care to be most effective and acceptable to patients general practitioners

should treat both illness and disease in their patients at the same time.” Another reason why this is important is due to the possibility that whiplash injury might create what Bury (1982) termed a biographical disruption. This means the nature of the incident is such that it brings into question what was previously taken for granted. There is a ‘before the whiplash injury’ when I could go about my usual daily activities and an ‘after the whiplash injury’ when I can no longer carry out what I used to do or I have to carefully plan how I might carry it out. The things ‘I’ did or thought is thrown into question and this in turn might effect how ‘I’ see myself. ‘I’ have changed from someone ‘who can’ to someone ‘who cannot.’ The disruption to the sense of self than might be created with experiencing a whiplash injury could be a consequence of the experience of pain that might come from the whiplash injury or the uncertainty that comes with not being able to carry out normal daily activities. Finlay (2003) explored the experience of a woman living with recently diagnosed multiple sclerosis. The impact of the changes that Ann experienced in her body were described by Finlay as a sense of bodily alienation and at the same time Ann recognised that she could not escape from her body. She was trapped in a world that was no longer familiar to her. Finlay also showed how bodily experiencing could not be separated from who we are and our experience of the world. In response to these changes, Ann started to live as if she was already incapacitated thereby limiting the possibilities of what she was able to do in the present. Hobbies and skills were lost to her as she sought to live in the now.

Critical health psychology perspectives offer two approaches that might be of use in understanding the meanings that one might make of the experience of whiplash injury. These are the discursive approach and the phenomenological approach. These

two approaches are similar in that they both have as their primary focus the subjective or personal experience and use qualitative methods to reach the meanings that lie at the heart of human experiences. These two approaches are important in counterbalancing the reductionist approach of the biomedical model (Yardley, 1997). They are able to do this because of the recognition that the power of language has for the understanding of meaning.

2. 4. 1 Discourse Analysis

Discourse analysis is concerned with discourse as the primary way in which individuals come to know and understand themselves. Potter and Wetherall (1987:178) state:

[O]ur focus is exclusively on discourse itself: how it is constructed, its functions, and the consequences which arise from different discursive organisation.

This means that if we are to understand phenomena such as emotions, then we need to study the ways in which people are said to negotiate meanings in conversation with one another (Willig, 2001). Burr (2003: 48) states that discourse refers to;

...a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events. It refers to a particular picture that is painted of an event (or person or class of persons), way of representing it or them in a certain light.

This means that the reality perceived by the individual is produced by an interaction that is shaped by expectations, culture and language, and that it would be futile to separate the phenomenon from the context in which it arises.

In discourse analysis, there are two main versions of analysis known as discursive psychology and Foucauldian discourse analysis. Discourse psychologists are concerned with interpersonal communication and look at how people use language to construct versions of 'social reality'. Foucauldian discourse analysts, while still concerned with language, go further than the immediate contexts within which the language is used to look at the relationships and positions that people might take in response to these experiences and how we define ourselves (Marks et al., 2005). One way in which a discursive approach could be used to increase our understanding of whiplash injury is through the use of a Foucauldian analysis. This could be used to examine the effects of the difference in positions that occur in the doctor-patient relationship or between the relationship in the healthcare organisation and the doctor, to show how that might impact on the experience of whiplash injury. However, this approach would tell us nothing about the bodily or subjective dimension in the creation of meaning for the experience of whiplash injury and whether or not this experience might have implications for clinical practice. Yardley (1997: 2) identified a problem with this approach in that the material or bodily dimension is not brought into the account.

...they privilege the socio-linguistic dimension to such a degree that the material dimension of human lives is denied or overlooked.

This criticism by Yardley goes right to heart of the issue, which is the denial that there is any necessary link between language and subjective or bodily experience. Also, the discursive approach would not be able to suggest that any one clinical approach has value over another and would have no role to play in changing clinical practice. The phenomenological approach differs from the discursive approach as it is able to make use of the subjective meaning that lies at the heart of people's lived experience.

2.4.2 Phenomenological approach

Radley (1997:50) draws attention to the role of the body in communication in several ways. The body communicates the appearance of being well or the appearance of being ill, the body also has a central role in communicating personal conditions and social status and is the medium through which individuals live and manage their lives. The phenomenological approach with its focus on lived experience enables the communication outlined above to be achieved. I will be discussing phenomenology in more depth in the next chapter. The phenomenological approach has enabled groundbreaking work to be achieved in understanding what it means to live with diverse health conditions such as multiple sclerosis (Toombs, 2002; Finlay, 2003), cancer (Franks, 1995:2001) and pain (Osborn, 2002). This approach has also benefited practitioners who are able to apply it to clinical practice (Madjar, 2001). An important reason why phenomenologists have been able to do this, is due to the groundbreaking work of philosophers such Merleau -Ponty in establishing the theory of embodiment and Leder a physician turned philosopher who expanded on Merleau – Ponty’s theory in relation to the human body and its modes of appearance in his work entitled *The Absent Body*.

2.4.3 Embodiment

Merleau-Ponty (1962) argued against a psychology that, like Cartesian dualism, separated the mind from the body (MacLachlan, 2004). He argued that the mind and body were not separate entities that could only be associated in a cause and effect relationship. Merleau-Ponty saw both mind and body as being inextricably bound together as one and that neither could exist without the other. This belief meant that

‘to be a body is to be tied to a certain [sort of] world’ and that if we study the world it should start with how it is perceived. The world as we experience it is grounded in our bodies (MacLachlan, 2004). Before there can be any objective or rational account of what is taking place, there has to be a subjective account of what is taking place. Through the activity of perception, the body is already engaged in the world. This is the body-subject and it is this that provides the base for reflection and cognition. This subject is always understood as being in-the-world. To be in-the-world is to exist in some physical form. ‘Existence is known through the body’ (Wilde 1999:27) or as MacLachlan (2004:4) puts it ‘our body is our infrastructure with the world’. This means that the perception of reality comes from the lived experience. This is important as it a way of maintaining the idea that we experience things from the perspective of a ‘lived body’ (Bendelow and Williams, 1995) and comprise of more than a psyche reacting to and separate from a body.

In health, the body is said to be phenomenologically absent (Leder, 1990: Maclachan, 2004) that is, we are not consciously aware of our body. This lack of bodily awareness enables us to focus or shift our attention on to the tasks or projects in hand. For example, I reach over to pick up and drink a cup of tea whilst I am sitting here writing this. I stop thinking about what I am writing and focus my attention on getting the cup of tea. I do this by automatically turning my body and using my arm and hand to reach out and pick up the cup of tea. I don’t think about how I need to turn my body or reach out using my arm and hand. I just do it. During illness or following injury this situation can change as the body comes back into our conscious awareness and becomes the focus of our attention. If we now go back to the cup of tea and I have a stiff neck, the stiffness in my neck would interfere with my movement and stop me

from automatically turning and reaching out to pick up the cup of tea. I become aware of the movements that I am carrying out. The effect of the stiff neck would make me think about how I was going to reach the cup of tea. I might even change the steps I take to reach the cup of tea. I might have to get up from my seat and go over and pick up the cup of tea instead of just reaching out for it.

The example of Finlay's work with Ann that I referred to earlier in section 2.4, gives a good illustration of this. Embodiment enables the adoption of a view that does not represent a replication of the biomedical and dualist perspective that is challenged by critical health psychology. The physical aspect of experience is recognised as being equally valid and physical phenomena such as pain, stiffness and fatigue can be included within emergent theories (Osborn, 2002). I will return to the concept of embodiment in chapters six and nine where I discuss the findings from the patient participants. As phenomenology draws on both the theory of embodiment and the personal experience, it is able to provide a useful approach to explore the meanings that are used by people to understand and make sense of the body and illness. This is illustrated in the following studies.

Toombs (2001) through the use of a phenomenological approach was able to legitimately use her own experience as a person living with multiple sclerosis and provide valuable insights into the experience of living with a disability. She was able to provide a powerful illumination of the bodily changes that took place as a consequence of the physical changes she experienced on her body through having multiple sclerosis that surpassed the 'mechanistic description based on the biomedical model of disease' (Toombs, 2001:247). The illness that she experiences is one that

makes it impossible for her to carry out activities that are taken for granted. She cites the examples of taking a walk round the house, climbing the stairs or carrying a cup of coffee from the kitchen. Phenomenology enabled her to illuminate what she described as the ‘experience of loss of mobility’ and makes explicit the ‘dynamic relation between body and world to provide insights into the disruption of space and time that are integral element of physical disability’. As well as disclosing the emotional aspect of physical dysfunction, Toombs (2001:248) described phenomenology as providing a window that gives invaluable information about the everyday world of those living with disabilities and that this can be of practical value for the clinical setting when trying to address the personal, social and emotional challenges that are presented with chronic disabling diseases.

Osborn (2002) used interpretive phenomenological analysis in his research to explore the experience of chronic pain. He interviewed nine women pain patients who were no longer in employment because of their chronic pain. He identified four broad themes from their accounts of living with chronic pain (1) Living with an unwanted self, (2) a self that cannot be understood or controlled, (3) living with a body separate from the self and (4) the social aspect of the self among others.

Osborn found that the participants’ sense of self was an important aspect of the experience of chronic pain. Living with their experience of pain was inseparable from their sense of self and this resulted in deterioration in their self–concept.

Helen struggled with contradictory aspects of her self almost as if she had lost her sense of who she was and was engaged in a battle for her identity:

It’s the pain, it’s me, but it is me, me doing it but not me but not me do you understand what I’m saying, If I was to

describe myself like you said, I'm a nice person, but then I'm not am I?
(Osborn 2002: 198).

Helen goes on to say 'how it makes her head all sour and horrible'.

Besides creating a conflict with their identity the experience of chronic pain also drew attention to the body:

...you can feel it like a solid thing, like something that's gone wrong. Yeah, like a mass, a bit of leather, in your back getting in the way, you know where your back is all the time, this thing you carry with you now, giving you hassle and getting in the way.
(Osborn 2002: 222).

These phenomenological accounts of illness show the emergence of new meanings in understanding what it is like to live and manage a particular illness that is not evident within the traditional medical model or the biopsychosocial perspective.

2.5 Aims of the study

This study sought to explore the meaning of whiplash injury from the patient's point of view alongside the doctor's point of view to see if this might have implications on how whiplash injury is understood and responded to by healthcare provision. This research is my attempt to respond to that challenge and this study will address the following questions:

- 1 What are the psychological and social consequences of sustaining a whiplash injury?
- 2 How is whiplash injury perceived and treated by professionals?
- 3 Are there differences between how the injury is perceived by the patient and how it is perceived and treated by practitioners?

- 4 What, if any, are the implications of the experience of whiplash injury for healthcare provision?

Chapter Three: Methodology

In this chapter I will discuss both the methodological approach and the research design that was taken to investigate the experience of having a whiplash injury from the patient's perspective and the doctor's perspective to identify how the experience of whiplash injury might be influenced by health care provision and address the following questions:

- 1 What are the psychological and social consequences of sustaining a whiplash injury?
- 2 How is whiplash injury perceived and treated by professionals?
- 3 Are there differences between how the injury is perceived by the patient and how it is perceived and treated by practitioners?
- 4 What if any are the implications of the experience of whiplash injury for healthcare provision?

I start by describing my own epistemological and ontological assumptions and outline how the research was underpinned by the principles of qualitative research. This will be followed by a justification for the adoption of an interpretive phenomenological approach. Finally I will demonstrate how this was applied to achieve the aims of this research study.

3.1 Framing the research

The explication of a theoretical position is an essential requirement in the conceptual development of the framework utilised by the researcher. This is important for two reasons. Firstly, the theoretical perspective adopted by the researcher ultimately

provides the context in which the research takes place. Secondly, it informs the development of the methodology that is the strategy or plan of action utilised by the researcher to gather and analyse data related to the research questions (Mason, 2004).

Crotty (1998:2) identified four basic elements inherent in that process. The four elements being:

- **Methods:** the techniques or procedures used to gather and analyse data related to some research question or hypothesis;
- **Methodology:** the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcome;
- **Theoretical perspective:** the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria;
- **Epistemology:** the theory of knowledge embedded in the theoretical perspective and thereby in the methodology.

These elements are seen to guide the way in which we come to answer questions about how and what we know and the research methods are the way in which this knowledge is obtained (Willig, 2001). Epistemology refers to the way people gain knowledge about the world and offers a range of positions that might be taken to view the world. Willig (2001:2) highlights the importance of being clear about what the objectives of our research are and what it is we wish to know, as this allows us to adopt an appropriate epistemological position and, in turn, the method or specific technique[s] that are used to collect and analyse the data. This is the fourth element of the research process. An element that is not discussed by Crotty specifically within his

framework is ontology. Ontology refers to the nature of the world; that is the set of assumptions that are held about what we understand about life.

Willig (2001:13) argued:

...ontological concerns are fundamental and that it is impossible not to make at least some assumptions about the nature of the world.

This means that the knowledge people gain about the world is already grounded in a set of beliefs about the nature of the world. This distinction is an important one, as traditionally biomedical research has placed the emphasis on objectivity and the ‘discovery’ of underlying causes that are reliant on quantitative methods. Whereas qualitative methods are concerned with the ‘interpretation of phenomena in terms of the meanings these have for the people experiencing them’ (Langdridge, 2007:2). The recent challenges for healthcare research on what are seemingly unexplainable health problems have opened up the possibility that subjective experience also has a part to play in understanding what it means to have a particular condition. This has led to people such as healthcare researchers and commissioners of health research to utilise qualitative methodology within biomedical enquiry (Murphy et al., 1998).

3.1.1 Epistemological and ontological assumptions

According to Madill et al. (2000), qualitative researchers have an obligation to make their epistemological position clear when conducting research as this assists others in the evaluation of the completed work. As I said in chapter two, I undertook this research to explore the meaning of whiplash injury from the patient’s point of view alongside the doctor’s point of view to see if this might have implications for how whiplash injury is understood and responded to by healthcare providers. My

experience of working with people as a health visitor has led me to the position whereby I take people's own experience as being important for gaining knowledge and understanding about their world. This is in contrast to the objectivist view of the world in which objects are said to exist independently of consciousness and can only be studied 'objectively' and 'scientifically' (Crotty, 1998). The epistemological focus of this research is experience and it is suggested by phenomenologists that people experience the world in a unique individual way (Becker, 1992). For example I am a mother and I can share an understanding of what it is like to be a mother through my own experience of motherhood but I can never fully know what it means for someone else to experience motherhood just as they can never fully know what being a mother means to me. That part of their experience is unique to them. Through undertaking this research I have become aware that I locate myself within what can be described as relativist ontology.

There are two main influences for me taking this position. The first comes from my exposure during health visitor training to the disciplines of sociology and psychology, in as much as they opened up my awareness to other ways of understanding people's experience and, more recently, when I did an MSc in Applied Behavioural Sciences. The second comes from my practical experience of working with people and seeing first hand how one person's experiences of the same phenomena can be both different from and similar to another person's.

I had intended to give an example from my practice as a health visitor to demonstrate this but I actually found this quite difficult to do. I was trying to remember a time when I had made a judgement about someone being a bad mother and my judgement

was changed due to me reflecting on the mother's experience. At first I thought my difficulty in being able to recall a particular example was because I had not practiced as a health visitor for some years. Then I remembered how very early on in my nursing career, a particular incident made me aware of how important it could be to try and understand what it was really like for the patient.

This particular incident happened whilst I was a staff nurse doing night duty in what was known at that time as the Casualty department. A young female patient had been brought to the department by ambulance. She had made an emergency call as she had started vomiting [being sick] and having stomach pains earlier on that evening and had thought it was getting worse. The ambulance personnel who brought her in commented on how dirty her home was, there was rubbish everywhere and it was no wonder she was being sick. She looked unkempt and not very clean. As I was booking her in I thought to myself 'another time waster, too much to drink. I'm not surprised she keeps being sick'. She was examined by the duty doctor and everything appeared to be normal. It was whilst I was talking to her and trying to reassure her when for some reason, I'm not sure what it was about her that made me change my mind and think there could be something else going on here. It might have been the tone of her voice, as she voiced her fears, her manner, something about the way she looked, or intuition. Whatever it was, something made me really listen to her and it made me change my response to her. I felt differently and felt it was important to keep her in for further observation. As we were quiet in the observation ward, the doctor agreed to my request. Several hours later her observations were stable but she was still complaining of feeling sick and she still had a lot of pain. Later on that night, I asked a surgical doctor who had been called to see another patient if they would do me a

favour. I explained the situation, and said ‘there was nothing obvious to explain why I felt that there was something going on’. In the end it turned out that this patient was having a miscarriage.

Looking back I can see how this experience began the journey that has brought me to where I am today. This has culminated in me recognising that there is always more than one way to understand an experience. Like Van Manen (1990) my ontological assumptions recognise the existence of multiple versions of reality and the possibility of other interpretations. From this position the notion of an absolute truth is rejected on the premise that there is no one objective and true reality that can be ‘discovered’ through the use of rigorous research instruments (Mason, 2002). To go back to Crotty’s (1998) elements of the research process these two elements inform the theoretical and philosophical stance that underpins this research. The underpinning epistemological position of importance here is phenomenology. This is due to the importance placed on the study of lived experience and how the individual makes sense of and understands their life involvements (Von Eckartsberg, 1998).

3.2 Phenomenology

Phenomenology arose out of a discontent with a philosophy of science exclusively based on material objects; science which failed to take account of human experience and the connections made between consciousness and objects that exist in the material world (Moustakas, 1994). Edmund Husserl (1859-1938), the founder of phenomenology, was a mathematician who became disenchanted with the scientists of the day as he thought that they imposed their own theories on the topics that they studied, thus were too quick to arrive at their explanations (Husserl, [1936] 1970).

Husserl's aim was to build a secure foundation for knowledge (Giorgi and Giorgi, 2003).

3.2.1 Development of phenomenology

Husserl was concerned with the origins of knowledge and how this presented itself to consciousness. In other words, how the world was viewed and experienced by us as humans. Husserl referred to this as the lifeworld. He saw this as providing the basis of all philosophical and human science research (Langdrige, 2007). In order to access this world of ours and others it was essential to return to 'the things themselves' as they appear to us and to bracket or set aside that which we think we know. The questioning and setting aside of the taken for granted ways of seeing the world is known as the epoché. Husserl maintained that by doing this it was possible to describe the essence of a phenomenon.

Heidegger (1889-1976), a former student of Husserl, in his influential book, *Being and Time*, ([1927]1962) built on this foundation and challenged the traditional Cartesian subject-object distinction which led to a dualistic universe and the separation of the mind from the body. This gap was bridged by conceiving our existence in relational terms, that is, as a field of openness into which things in the world appear and reveal themselves dynamically. Persons are not separated from a world that is thought to exist independently, but are personally involved in a complex network of interdependent ongoing relationships that 'demand response and participation' (Von Eckartsberg, 1998:11). The world comes into existence for us in and through our participation in the world. This is known as 'being-in-the-world'. The network of interpersonal relationships that people have is known as 'being-in-the-

world-with-others'. From this phenomenology developed an interpretive understanding of the human being, that is Dasein in total. Dasein is the term given by Heidegger to the human, 'the being-there' of human existence (Svenaesus, 2001) and he claimed that Dasein's own being is intrinsically temporal in a unique existential sense and that this being is always reaching out towards its future. Heidegger identified the importance of time for people, as time forms the basis for their understanding of what it means to exist. The present, by 'its very nature, always involves our past and our future: Dasein is always projecting itself towards future possibilities' (Langdrige, 2007:30).

Langdrige also pointed out that the human being or Dasein is not an object like a stone. Dasein is not a noun but a verb; existence for humanity at the very least requires life to be created and not just lived. Langdrige (2007:30) described this as:

...we are meaning making machines always making sense of ourselves and others, even if this is not always in conscious awareness.

This means that human beings have a particular understanding of themselves although this might not necessarily be explicit. We do not automatically know in what way we understand ourselves although we have an existence. That is, we have a relation to our own existence. For Heidegger, language or discourse was the medium through which we gained our understanding of the world. This addition is often referred to as the hermeneutic turn and paved the way for an interpretive understanding of experience.

Gadamer, who was influenced by Husserl and Heidegger, contested Husserl's belief and established a contrasting position concerning the achievement of epoché. Gadamer ([1975] 1996) believed that it was neither possible nor productive, to

suspend all our prejudgements and presuppositions about a particular phenomenon to achieve epoché. Gadamer emphasised the historically and culturally situated nature of understanding and he believed that speech, and in particular conversation, is at the heart of all understanding. Conversation is seen as that which enables a shared understanding and ultimately an interpretation to be made. This understanding is achieved through self awareness. Becker (1992:14) describes this as 'self reflective'. Self awareness 'signifies that we have a relation to our own existence in asking what it means to be there at all' (Svenaesus, 2001:90). Our very existence is already one of understanding. I already understand myself and the world by my approach and my own situation. For example, I am female, I am a nurse or I am unemployed and so on. This approach is called the hermeneutics of existence (Von Ecksartsberg, 1998; Moran, 2000).

Phenomenology has continued to change and develop from its roots in philosophy through the influence of the disciplines of psychology and sociology into the differing perspectives of phenomenology that we know today. These perspectives come under two traditions and are often referred to as the Husserlian descriptive tradition, and the interpretive or hermeneutic tradition, also referred to as existential-phenomenology (Heidegger, 1962; Merleau-Ponty, 1962). Whilst there are differences between the traditions or perspectives within phenomenology they are drawn together through a fundamental requirement to attend to the individual's point of view and the meanings attributed by them to their actions (Crotty, 1998; Caelli, 2001; Spinelli, 2005). Phenomenology opens our awareness to differing perspectives without attempting to justify or explain the different constructions (Butt, 2004). As was said in the last chapter, this study not only seeks to understand what the experience of whiplash

injury might be like for the person who has suffered a whiplash injury, but also seeks to understand the influence of health care on that experience.

3.2.2 Key ideas

In the next section I will look at some key ideas in phenomenology. These are intentionality, temporality, epoché, essence and lifeworld.

Intentionality

Husserl's notion of intentionality provides the cornerstone to phenomenology's understanding of the nature of consciousness. Moran (2005:6) documents Husserl's meaning of intentionality as "'directedness' or 'aboutness' of conscious experience" and highlights the influence that his tutor Brentano had in the development of this concept. This cornerstone is seen in the phenomenologists' belief that consciousness is always a consciousness of something and that an object is always an object for someone. We see a particular object, we feel an emotion towards a particular situation or person. In other words, the object cannot be described adequately if it is apart from the subject, likewise the subject cannot be adequately described from the object. This means that as humans we cannot be described apart from our world, similarly our world, which is always a human world, cannot be described apart from us (Crotty, 1998).

The process by which the mind is said to reach out into the world in order to make sense of what it experiences, is known as intentionality. The basic interpretive act is to experience the world in terms of objects or things and whatever sense we make of the world is intentionally derived by actively reaching out to those objects. The very

process of intentionality makes clear that, as humans, we can never have direct access to or knowledge of the real world as it is. However, what can be said is that at a most basic level of consciousness an interpretive act has occurred:

Through intentionality, the sensory data at our disposal, which respond to the unknown stimuli emanating from the physical world, undergo a basic, unavoidable 'translation' or interpretation that leads us to respond to the stimuli as if they were objects.
(Spinelli, 2005: 15).

Intentionality is the central assumption of phenomenology (Spinelli, 2005; Langridge, 2007).

Husserl introduced the terms noema and noesis to refer to two different aspects of experience. Noema refers to what is experienced (the object) and noesis refers to the way it is experienced (by the subject). I am looking out of my window and notice the appearance of green stems out of the ground and I begin to think about longer brighter days, the warmth of the sun and I feel more cheerful that spring is here. The green stems would be the initial focus of my experience. The noematic focus of my experience is the green stems, whereas the noetic focus of my experience are my feelings, thoughts and associations that I bring to the experience and the thought of spring makes me feel more cheerful. Whilst these terms can be defined in isolation, they are inevitably related:

Every experiencing has its reference or direction towards what is experienced, and contrarily, every experienced phenomenon refers to or reflects a mode of experiencing to which it is present.
(Ihde, 1986: 42).

Intentionality then is the relationship between the noema and noesis. Husserl suggested that it was possible for the subject (or the researcher) to transcend the

relationship between noema and noesis and view intentionality from the outside. This is often referred to as taking a ‘God’s eye view’ (Merleau-Ponty, [1945] 1962) of the experience.

Temporality

Temporality, which means our experience of time, was a key feature for Heidegger’s book *Being and Time*. Whilst our experience of time is always of the here and now or the present, it also involves our past and a projection of the future. Time is also measured by the clock and can be broken down into units such as minutes, hours and weeks. This way of seeing time gives it a linear dimension often described as past, present and future (Becker, 1992) and this way of looking at time helps us to give a structure or routine to our activities. Our experience of time can be quite different to clock time. What is like two minutes on a clock when we are doing something enjoyable can flash by. At other times, when we are doing something we do not want to do, two minutes can seem like hours or if we have been given bad news time can seem to stand still.

Epoché

Epoché is the term used to describe the step taken when we attempt to recognise and set aside our own preconceived ideas about the phenomenon we are considering. Husserl maintained that human existence was characterised by the natural attitude. This means our everyday way of experiencing the world with all our taken for granted assumptions. The practice of epoché is also known as bracketing. The process involves suspending, or setting to one side, scientific knowledge and our own personal preconceptions. Langdrige (2007: 17) said ‘the core of epoché is doubt’. By

this, he meant that we doubt the ‘natural attitude or biases of everyday knowledge’. This is our ordinary way of seeing things, where taken-for-granted assumptions and stereotypes influence our responses. The natural attitude characterises the fabric of human existence. The aim of epoché is to enable the researcher to describe the ‘things them-selves’ and attempt to set aside ‘all those assumptions we have about the world around us’ (Langdrige, 2007: 18). Husserl believed that whilst this might be difficult to achieve it was possible to completely step outside of our own preconceptions. The later existentialist philosophers, in particular Merleau-Ponty, a philosopher and psychologist, criticised what he termed ‘the God’s eye view’. Merleau-Ponty did not believe that it was possible to completely step out of our own experience and produce ‘incontrovertible truths about our experience of phenomena’ as ‘people are essentially connected to the world through embodied consciousness’ (Langdrige, 2007:37). This relational aspect means that our own experience can never truly be fully suspended but what we can do is strive to be aware of our own personal prejudices and the interaction between our pre-understanding or old way and contemporary or current way of understanding the phenomenon. By doing this, a new or renewed construction of meaning can emerge (Van Manen, 1990).

Essence

Essence is the term Husserl used to describe that element which makes a particular phenomenon what it is. The essence is that which is left when we have taken away personal and societal preconceptions about the phenomenon. The essence is also known as a universal structure of the particular phenomenon. However, this is different from the way essence is used within essentialism where it refers to the belief that people or phenomena have an essential or unchanging structure. The concern

with essence is more strongly associated with Husserl's descriptive phenomenology and that interpretive phenomenologists on the whole are less interested in it. Van Manen (1990) talks about essential themes but in a different way to the Husserlian view, which is that which makes a thing what it is. Van Manen characterises this as themes which are essential to this particular interpretation.

Lifeworld

Husserl used the term *lifeworld* to refer to the world of concrete experiences as it is lived by people (Langdrige, 2007). Phenomenology emphasises the understanding of lived experience of the lifeworld. Merleau-Ponty (1962) in *Phenomenology of Perception* draws attention to the embodied aspects of human nature. He used the term 'body-subject' for 'the mind-body unity'. The notion of embodiment is a central feature of his work that has enabled the reclamation of the 'body-subject' as 'the rich original ground of human existence' (Becker, 1992: 17).

3.2.3 Descriptive versus Interpretive Phenomenology

Van Manen (1990) distinguishes two types of descriptions when attempting to describe lived experience. One description is of the lifeworld as it is immediately experienced whilst the other is of the lifeworld that is revealed through some form of expression, for example, language. The expression of that experience through the use of language is said to be an interpretation. The first type of description would fit with what is described as the Husserlian tradition, whereas the second description is in keeping with the Heideggerian interpretive tradition. The descriptivists have remained close to the philosophical underpinnings of Husserl's descriptive phenomenology.

They maintain that ‘unified meaning can be teased out and described precisely as it presents itself’ (Giorgi, 1992:123) and that description is fundamental in accounting for variety in phenomena. The interpretivists consider that meaning is unique and cannot be described and that interpretation is essential if we are to move beyond the data (Rapport, 2005:130). This has led descriptivists like Giorgi (1992) to criticise interpretivists for their accounts of a phenomenon as being open to various other interpretations. Interpretivists like Paley (1997) have responded with the counter argument about the authenticity of descriptive accounts by disputing how a description of a phenomenon can be a unique experience and at the same time reveal commonalities about the structure of the experience.

The theoretical differences between descriptive and interpretive phenomenology have implications for the different practical positions emphasised by the two approaches.

Rapport (2005) emphasised these difference that include:

1. The descriptivist attempts to elucidate meaning as it directly appears in consciousness, whilst the interpretivist engages in clarification of meaning to produce theoretical models;
2. The descriptivist sees the researcher as the main judge of validity, whilst the interpretivist looks to external judges to validate findings;
3. The descriptivist proposes that all interpretation could be described, whilst the interpretivist argues that interpretation is the only goal of research, as by nature human beings are interpretive.

Rapport also recognises that some phenomenologists (e.g. Todres and Wheeler, 2001) acknowledge the complementarity of the different perspectives. For descriptivist phenomenologists, transcendental phenomenology is both a theoretical foundation

and a method for the practice of phenomenology. Interpretive phenomenologists separate theory from practice. The philosophical underpinning of interpretive phenomenology provides the foundation for method rather than a model for practice. The methods of interpretive phenomenology are seen as a guide to practice and not a set of rules that determine a distinct approach.

3. 3 Phenomenological research methods

In order to study how the world appeared to consciousness Husserl proposed a phenomenological method of investigation which could be applied to all analyses of experience. He argued that the principle function was to strip away as much as possible the interpretational layers so that a more adequate, but still approximate and incomplete, knowledge of the 'things themselves' could be arrived at.

3.3.1 Principles of descriptive phenomenological research

This method was underpinned by the principles of epochē, phenomenological reduction and imaginative variation. This method as described by Spinelli (2005: 20 - 21) consists of three steps, which are:

- Step A: The Rule of Epoché.

This rule urges us to set aside our initial biases and assumptions and prejudices of the things, to suspend our expectations and assumptions; to bracket all such temporarily and as far as possible so that we can focus on the primary and immediate data.

- Step B: The Rule of Description.

The essence of this rule is ‘describe, don’t explain’. It urges us to stay focused on our immediate and concrete impressions to maintain a level of analysis with regard to these experiences which takes description rather than theoretical explanation or speculation as its focus.

- Step C: The Rule of Horizontalisation.

Having stuck to an immediate experience which we seek to describe, this rule further urges us to avoid placing any initial hierarchies of significance or importance upon the items of our descriptions, and instead to treat each initially as having equal value or importance.

At the heart of descriptive phenomenology is the call to ‘return to things themselves’ and its adherence to the Husserlian method. Descriptive phenomenology as a method emerged through the work of Amedeo Giorgi and colleagues carried out at Duquesne University during the 1970s. This is a well established form of phenomenology that is not confined to psychology as it has been used across many disciplines such as education and nursing. Descriptive phenomenology is concerned with lived experience and attempts to describe the ‘things in their appearing’ (Langdrige, 2007:86), rather than attempting to explain underlying causes. This can only be achieved through the focus on first person accounts and a description of the immediate experience of the phenomenon:

*...we focus on experience of the world as it is lived by people through their own perceptions of the world and, through this, come to understand the person in the act of perceiving.
(Langdrige, 2007:17)*

3.3.2 Giorgi's descriptive method

Giorgi's descriptive phenomenological method of analysis consists of four stages (Giorgi, 1985; Giorgi & Giorgi, 2003). These stages are: reading for overall meaning, identifying meaning units, assessing the significance of meaning units and presenting a structural description.

The first stage comprises reading of the text, this is usually the interview transcript, at least once before any attempt is made at analysis. This stage is carried out with the principle of epoché in mind, that is, the bracketing of one's preconceptions. The second stage is when the text is broken down into smaller units of meaning. These 'meaning units' show when a meaning in the account has been identified by the researcher. During stage three, the meaning units are assessed for their significance. The penultimate stage is when a structural description of the account for each participant is produced. This is achieved through multiple readings and the use of imaginative variation where the true nature of the essence is revealed through an examination of the experience under investigation from different perspectives. The final general structural description represents the essence of the phenomenon being investigated. Although Giorgi recommends the production of a single structural description across all cases, it is recognised that in some instances there might be more than one structural description due to insufficient commonality.

I think the main difficulty with this method is related to epoché and whether or not this condition can ever be achieved. I think this is demonstrated during the second stage when it is important for the researcher[s] not to impose any theoretical ideas defining the units during this stage. If there is a strong possibility that two people from different backgrounds might ascribe different meaning to the same material how

can a researcher who has any personal knowledge of a particular experience be able to completely suspend or remove all that they know to achieve epoché?

3.3.3 Interpretive phenomenological research

A hermeneutical phenomenological approach starts with events, with what takes place in human existence. (Kugelman, 2004:44).

Interpretive phenomenology, like descriptive phenomenology, requires the researcher to return and investigate the phenomenon as it is experienced in the lifeworld. This is resonant with Husserl's call 'to return to the things themselves'. However, interpretive phenomenological research recognises that there is always more than one interpretation of a particular experience. Whilst these different interpretations offer richer and deeper descriptions about the particular phenomenon, it is never truly possible to arrive at full understanding of what an individual's particular experience might mean. Van Manen (1990) distinguishes two types of descriptions when attempting to describe lived experience. One description is of the lifeworld as it is immediately experienced, whilst the other is of the lifeworld that is revealed through some form of expression, for example, language or art. The emphasis placed on speech as the medium for interpretation also places the researcher in the position of being an active participant in a dynamic process:

...conversation where we accept the genuine intentions of the other person whom we wish to understand while also recognising the very particular situated nature of our own position. (Langdridge, 2007:42).

As discussed earlier in chapter one, this requirement also places a responsibility on the researcher to be aware of their impact on the phenomenon being investigated and the need to take a reflexive stance.

Interpretive phenomenologists separate out the theory from practice as they view the philosophical underpinnings of hermeneutic phenomenology as the foundation of method rather than a model for practice. This separation is an important one, as the strength of the hermeneutic approach for many researchers, lies in its lack of a formal method. This lack of formality is due to the way in which researchers see the method as ‘emerging uniquely in the context of the phenomenon being investigated’ (Langdrige, 2007:109) and has led to ‘a small family of methods based principally on the philosophy of the later Husserl and Heidegger’ (Langdrige, 2007:108). Included within this family are interpretive phenomenological analysis (IPA), hermeneutic phenomenology and template analysis (TA).

3.3.4 Principles of Interpretive phenomenology

Two key principles underpin interpretive phenomenology. The first is the requirement to attend to how people make sense of their personal and social worlds through a detailed examination of the individual’s personal account (Smith, 2008). The second is the way in which the researcher is seen as being engaged in the ‘co-construction’ of knowledge (Langdrige, 2007:59). The co-construction means that the researcher’s experience has a position alongside that of the research participant and for this reason reflexivity plays an important role. The role of reflexivity stems from Husserl’s rule of epoché (see page 77) and the requirement to step outside of our own experience. The researcher has to be aware of the way in which their questions, choice of method

and their own assumptions and prejudices, might impact experiences under investigation. I would agree that it is not possible for the researcher to ever achieve this ideal. They can, as far as possible, recognise and disclose their own assumptions within the research. In chapter one, I began by disclosing my position within this research and have adhered to that requirement throughout the research process. My use of self in the research process can be seen in this chapter on page 69. I also used my professional status and personal experience of whiplash injury to negotiate access to healthcare professionals and in construction of the interview schedule. In chapter six I reflect on my own personal response to the interviewees and in chapter seven I reflect on the difficulty in letting go of my personal, professional assumptions and biases.

3.3.5 Phenomenological approaches to data collection

Earlier in this chapter, I drew attention to the strength of phenomenology being the lack of a single formal method. However, the lack of a single prescriptive account is not the same as saying the methods are disparate. Van Manen (1990:30-31) identified six methodological themes which can be used as a set of guidelines to select the appropriate method[s] for approaching the data. These themes are:

1. Turning to a phenomenon which seriously interests us and commits us to the world;
2. Investigating experience as we live it rather than as we conceptualize it;
3. Reflecting on the essential themes which characterize the phenomenon;
4. Describing the phenomenon through the art of writing and rewriting;
5. Maintaining a strong and oriented relation to the phenomenon;
6. Balancing the research context by considering parts and wholes.

‘Turning to the nature of lived experience’ illustrates the researcher’s commitment to the phenomenon or experience. The experience is interpreted by the researcher:

...phenomenological research does not start or proceed in a disembodied fashion. It is always a project of someone: a real person, who, in the context of particular individual, social and historical life circumstances, sets out to make sense of a certain aspect of human existence.
(Van Manen, 1990:31).

Van Manen’s call for the researcher to investigate experience as it is lived, echoes the call by Husserl to return to the ‘things themselves’. By returning to and reflecting on that experience the meaning will be revealed. The ‘art of writing and rewriting’ enables the phenomenon to be described in a thoughtful manner. This is achieved through the use of language to reveal an aspect of lived experience as it is. According to Van Manen (1990:33) it is essential that a strong and oriented relationship to the phenomenon is maintained by being oriented to the research question. My own personal experience gave me the energy, enthusiasm and commitment to complete this project and overcome the obstacles and challenges experienced along the way. Van Manen’s final theme requires the researcher to balance the research context by considering parts and whole. The process of interpretation begins with the puzzle of connecting the parts to the whole. Like a jigsaw, the whole picture is required to understand the parts, and the parts are required to understand the picture. Some anticipation of what the picture looks like helps us to modify or change the parts that make up the whole. Gadamer’s ([1975] 1996) focus on language reveals being within a particular cultural and historical context. A coming together of the horizons between researcher and participant are revealed through the language of the interview. There is a constant movement between the overall understanding of the story from the

‘contextual givens’ to its various parts and back again. This is similar to what Addison (1984) described as the hermeneutic circle. Van Manen suggested that the researcher is free to use the themes in any order and can choose whether or not to use some or all of the themes. These exhortations by Van Manen are applicable to all phenomenologists irrespective of the chosen phenomenological method employed to seek out the meaning of experience.

3.3.6 Interpretative Phenomenological Analysis (IPA)

IPA whilst being a theoretical perspective is also a research method and is the most widely used method in carrying out interpretative phenomenology. The method is phenomenological as it involves a detailed examination of the participant’s lived experience. Smith and Osborn (2003: 53) emphasise the dynamics between researcher and participant within the research process. Smith and Osborn (2003) refer to the use of ‘double hermeneutic’. This means that the researcher is trying to make sense of the sense making activities of the participant and this also reveals how the researcher can never entirely step out of their own position.

Analysis

The researcher, in trying to make sense of the participant’s world and produce a thematic analysis, spends a considerable amount of time with the transcript. This is to allow familiarisation of the data and to identify major themes. The analysis begins with one transcript and goes through several stages. These stages appear to be quite prescriptive in the way they are applied. The first stage is when the transcript is read and re-read and notes are made of anything that seems meaningful about the data into the left hand margin. These notes could be summaries of what had been said or key

points. Initial notes are transformed into more meaningful statements. These comments might be associated with theoretical concerns. During stage three the themes are listed chronologically on a separate piece of paper. The themes are examined to see if there are any that come together to form a cluster. Some themes will merge together while others might need a further breakdown or even be removed as they are not helpful in producing a rich understanding. Whilst this is taking place, the researcher will constantly be referring back to the text and checking it with the emerging analysis. During the final stage a coherent table of themes is produced. Identifiers are given to the themes to allow identification in the transcript. Once this has been completed, analysis of the next case can begin. Finally, a master table of themes for the study is produced.

Whilst IPA is the most popular approach used to conduct interpretive research studies, its application can be limited with research such as this that has a strong a-priori focus. I knew that I specifically wanted to look at the first medical consultation that takes place with a patient who has a whiplash injury. This meant my research begins with two different perspectives. Keeping in mind Van Manen's call to select a method that is best suited to approaching the data there is another lesser known method which can accommodate more than one perspective that is worth considering for this study. This method is known as template analysis.

3.3.7 Template Analysis (TA)

TA is an alternative method to IPA (Langdridge, 2007). TA was developed from the work of Crabtree and Miller (1999) by King (2004). The term 'template analysis' refers to a varied but related group of techniques that organises and analyses data

thematically. At the heart of TA lies the template that comprises a list of codes, hence its name 'template analysis'. The organisation of the template represents the relationship between the themes as identified by the researcher. As a technique, TA can be used with different epistemological positions and with a positivistic approach and qualitative data. On the one hand, it can be used in positivistic research which is concerned with the discovery of underlying cause of human action and to demonstrate coding reliability and researcher objectivity. However, TA also works well with a position that assumes there are multiple ways of interpreting the data (Madill et al., 2000). This means that issues of coding reliability are irrelevant whilst issues such as 'the reflexivity of the researcher, the attempt to approach the topic from different perspectives and the richness of description produced are all important requirements' (King, 2004). Thus it is appropriate for phenomenology. TA also differs from other approaches such as grounded theory as the researcher is able to use a-priori codes to guide the initial development of the template. This was an important consideration as I knew that there were particular aspects of the patient and doctor accounts that I wanted to examine that concerned the treatment and management of whiplash injury. TA like IPA is concerned with making sense of the participant's world and produces a thematic analysis from the interview transcripts. I will return to a fuller discussion of the practical application of TA in the method section of this chapter.

3.3.8 Justification of chosen method

Having established that both IPA and TA are suitable methods for conducting my inquiry into the experience of whiplash injury, I am going to say why TA is my chosen method and not IPA. My choice is guided by theoretical and practical considerations.

The first and substantive consideration for me comes from the concept of epoché. Whilst IPA takes the view that the researcher can never entirely step out of their natural attitude and is actively involved in the process of interpretation, it seemed to me that as an insider, at the very least, I would require some form of tool to assist in that reflexive process. TA appeared to me to offer a way of illuminating my natural attitude in approaching the data. The second consideration comes from the requirement to accommodate the multiple perspectives. I have already said that I subscribed to the idea that each person's experience is unique and individual and that these different experiences from patients and doctors might further our understanding of whiplash injury and might reveal implications for practice. TA is already recognised as being able to support multiple interpretations. TA appeared to me to be a very practical way of managing the data through the structure of the template. There are a number of healthcare studies (King et al., 2002; Rodriguez, 2009) that have used template analysis and for this reason I thought that it might also be a useful tool that practitioners could adopt when drawing on patients' own experiences to assist in the evaluation of the effectiveness of existing interventions, or identify other potential interventions aimed at managing a particular condition. TA has also been used within the context of Van Manen's style of hermeneutic phenomenology to explore the lived experience of Being and caring for a child with a Life Limiting Condition (Rodriguez, 2009).

I have tried to keep in mind Van Manen's methodological themes alongside my chosen phenomenological method template analysis (TA). In chapter one, I have drawn attention to my own experience of having a whiplash injury and I have

continually strived to avoid being trapped in the natural attitude and my pre-existing understandings by reflecting upon and explicating the impact of my experience for this research throughout this thesis. In chapters four, five, six, seven and eight, ‘investigating experience as we live it’ (Van Manen, 1990:53) has enabled me to obtain descriptions of whiplash injury from the different perspectives of patients and doctors. This has involved analysing and reflecting upon that experience to produce idiographic and thematic aspects of those accounts.

Having located this research within an interpretive phenomenological perspective, I will now go on to translate methodology into method. Method is the final element that describes the steps that are taken during the research process.

3.4 From Theory to Practice: the method

In this section, I give an overview of the method involved in conducting this exploratory study, with the aim of answering the following questions:

1. What are the psychological and social consequences of sustaining a whiplash injury?
2. How is whiplash injury perceived and treated by professionals?
3. Are there differences between how the injury is perceived by the patient and how it is perceived and treated by practitioners?
4. What, if any, are the implications of the experience of whiplash injury for healthcare provision?

More detailed accounts for each phase appear in chapter four and chapter seven respectively.

3.4.1 Design

As detailed in chapter one, the current study arose out of my own experience of having whiplash injury. This brought me to the realisation that very little appeared to be known about the actual impact of whiplash injury on lived experience, or about how a better understanding of whiplash injury might have implications for the way the injury is treated by healthcare providers. The aim of the study was to illuminate the lived experience of the phenomenon of whiplash injury and to explore the influence of healthcare providers on the phenomenon through a phenomenological framework and, in so doing, highlight the potential implications for healthcare providers. The study was designed to be carried out in two phases and comprised two sample groups of patients and doctors. Phase One consisted of whiplash injured patients who were recruited through GP practices using a combined approach of retrospective and prospective sampling. Phase Two consisted exclusively of doctors, rather than other health care professionals such as physiotherapists or osteopaths, who treat patients with a whiplash injury. This was because doctors are responsible for diagnosing and managing the initial care of the condition and, in terms of National Health Service treatment, they would be responsible for making the referral to the physiotherapy service or any other department that may be used to give advice on the management and/or treatment of the condition. Doctors were invited by letter (see appendix 2) to take part in the study.

3.4.2 Sampling and Recruitment

Purposive sampling is the most commonly used method in phenomenological inquiry (Crotty, 1996) and is the preferred choice for interpretive phenomenological studies (Langdrige, 2007). This method of sampling selects participants on the basis of their particular knowledge of a phenomenon, with the purpose of sharing that knowledge. Purposive sampling was used in both phases to obtain patient and doctor participants and the recruitment of general practices.

3.4.3 Data Collection

Phenomenology is concerned with understanding and interpreting experience through the use of language. The preferred or commonest method of data gathering is the interview (King, 2004). The format of the interview can be either structured or semi-structured and the interviewer has a set of questions on an interview guide which focus on the issues to be covered (King, 2004; Shaw, 1999). In the semi-structured interview, the schedule consists of topics which each participant is asked about, although the questions may differ according to the responses of the participant. The interviewer is allowed to probe the participant to seek clarification and obtain more complete answers. Unlike the structured interview, there is flexibility in the sequencing of the questions according to the responses given (Robson, 2000; Shaw, 1999). The relationship between interviewer and interviewee is also seen as a key feature in qualitative research (King, 2004). The rapport and empathy that is established within the relationship is an essential requirement for self disclosure although this may lead to the disclosure of powerful emotions. For this reason, King (1996:181) compares the qualitative interview with the counselling interview.

However, King goes on to say that unlike the counselling interview the focus of the research is on the needs of the interviewer and not the interviewee.

In this research, I sought to gather subjective accounts of the experience of whiplash injury from two different perspectives. These perspectives were from those who had experienced a whiplash injury and those who treated whiplash injury (i.e. doctors). Data were gathered in two distinct phases and semi-structured interviews were used with participants and audio recorded. A problem arose with the audio recording of James first interview which failed to record. This meant that I had to write down as much as I could remember about the interview so that I could include his data in the data set.

3.5 Negotiating Access to Trusts and Practices

Full support to undertake the study was gained at the outset from the Primary Care and Hospital Trusts. This was important in being able to gain access to doctors, GP practices and thereby access to patients. I wrote to the chief executives of the various trusts outlining my intention to conduct this research with the aim of seeking their support (see appendix one). I explained who I was and how my personal interest in whiplash injury had come about. Their support involved introducing me to key personnel in the relevant departments; for example the research and development or Accident and Emergency department, to assist in recruiting patient participants, or to allow their staff to be interviewed as participants. I have no doubt that the support I was given at this time, in being directed to key personnel within the trust to assist me, owed as much to my professional standing as it did to the research topic of whiplash

injury, especially as the trusts were undergoing major organisational changes. Unbeknown to me at this time, these changes were to have practical implications for obtaining ethical approval and gaining access to patients. At the time of commencing this study, Kirklees was covered by Huddersfield and Dewsbury NHS Trusts. The organisational changes that were taking place in relation to the separation of Primary Care from Secondary Care led to the creation of five separate trusts.

3.6 Ethical Considerations

All research can be regarded to have ethical implications that need to be considered at all stages of the research. The British Psychological Society (2002) and Nursing and Midwifery Council (2002) set out ethical principles that researchers need to take into consideration. These principles cover informed consent, confidentiality and anonymity, protection of participants and researcher safety.

3.6.1 Informed Consent

Informed consent was sought from all those who agreed to take part in the study. Potential participants were given written information (see appendix 4) about the study and the opportunity to discuss the study before deciding to take part. Preliminary consent to take part in the study was given by returning a form (see appendix 5) in a prepaid envelope to indicate their agreement to being contacted by the researcher. The participant was informed of their right to withdraw from the study at any time and that this decision would not affect any care that they might be receiving. Permission for the interview to be tape-recorded was also sought from the participant and written consent was obtained. Agreement to continue in the study was also confirmed at

subsequent interviews. Consent was also obtained to allow anonymous data from this study to be used for further research papers by the research team (see appendix 7).

3.6.2 Confidentiality and Anonymity

Participants were informed that all data collected during the course of the research was kept in a secure place and the tapes would be destroyed on completion of the research. The normal practice from the Schools committee here is that the audio recordings will be destroyed five years after the end of the project which in this case will be from the award of my PhD. Care was taken to remove any potentially identifying information from the transcripts. Copies of transcripts of the interviews were given back to the individual participant so that they could make comment on what they had said before the data was analysed. None of the participants commented on returned transcripts. The participants were given pseudonyms so that the identities of individuals would not be revealed in the findings.

3.6.3 Protection of Participants

The researcher has a duty to protect participants from any possible physical or mental harm during the study. It was not anticipated that these interviews would be any more distressing than a conversation with a healthcare professional, family member or close friend. Before starting the interview, participants were reminded that they were free to withdraw from the study and that they were not obliged to answer any of the questions asked. Participants were informed that they were free to take a break or terminate the interview at any time if they felt uncomfortable, and that they do not have to give a reason as to why they are ending the interview.

3.6.4 Researcher Safety

The researcher also has a responsibility to ensure that, like the participant, they are not exposed to any physical or psychological harm. A member of the supervisory team was informed about the time and duration of the interview that was being carried out. On completion of the interview I contacted the designated person to let them know that the interview had been completed and I was safe. I also carried a mobile phone with me on all field visits.

3.7 Obtaining Ethical Approval

The research required ethical approval from an NHS research Ethics Committee. This was because both NHS staff and patients were the intended participants. This was when I realised that the organisational changes that had taken place within the trust meant that if all five trusts were involved in the study it would become a multi centre study. This would have required ethical approval from a Multi-Centre Research Ethics Committee whereas prior to this it would have been the Local Research Ethics Committee (LREC). After much consideration I decided that pragmatically it would be better to undertake the study in South Kirklees which comprised three trusts. I prepared and submitted an ethics application for consideration at University level. Following modifications I submitted the application to the LREC in July 2002. This application was accepted by the LREC September 2002 (see appendix 8).

My elation at receiving ethical approval was short lived as I had to suspend all contact with healthcare personnel and staff due to the introduction of Research Governance within Primary Care. This process was completely beyond my control and I had to

wait whilst my application went through yet another organisational process. The most difficult aspect of this was that I did not know what timescale was involved. I knew from my own experience of working in the NHS that this might be a long wait and all I could do was sit back and wait. I hoped that this process would only take a few months but in fact it took until July 2003 before I was given approval to proceed with my research (see appendix 9).

Chapter Four: Phase One - Patients: Method

In this chapter I begin by discussing the design of Phase One and the issues that I needed to consider before recruitment of patient participants for this phase of the research could be undertaken. This will be followed by a detailed account of patient recruitment, interview procedure and data analysis.

4.1 Design

The aim of phase one was to answer the following questions;

- What are the psychological and social consequences of sustaining a whiplash injury?
- Are there differences between how the injury is perceived by the patient and how it is perceived and treated by practitioners?
- To identify what, if any, are the implications of the experience of whiplash injury for healthcare provision?

It follows then that these broad aims had to be translated into questions that were flexible enough to access people's own accounts of their experience of whiplash injury and also reveal how the same phenomenon was experienced by the same person over time. This meant that I needed to obtain the same people's accounts of the experience of whiplash injury at different stages, instead of interviewing different people at different times. In-depth semi-structured interviews were carried out at the first interview (appendix 11) following assignment to the study, to find out what the consequences of the injury were at that moment in time. The second in-depth semi-structured interview (appendix 12) took place after three months, to identify what the consequences of the injury were at that stage. A follow-up telephone interview (appendix 13) was carried out after six months. The telephone interview helped to

maintain contact with the participant between the second and final interview to increase the likelihood of the participant completing the study. The final in-depth interview (appendix 12) took place twelve months after inclusion into the study. Semi-structured interviews were carried out between December 2003 and August 2005 with patients who had experienced a whiplash injury.

4.1.1 Sampling Strategy

The use of a combined approach to sampling was based on two main considerations. The first was existing epidemiological data or more accurately the lack of data on whiplash injury. Kirklees' 1999 accident statistics showed that out of 1,655 accidents 1,435 were classified as slight. A problem with the collating the number of slight injury comes from the lack of differentiation between injuries that are considered slight injuries. Whiplash injury is classified as slight but there is no way of extracting the number of whiplash injuries from the data. Epidemiological information held centrally by the Public Health department was also unable to provide accurate statistical information on the incidence of whiplash injury (Smith, personal communication). At that time, statistical information on whiplash injury was not routinely collected. Personal communication with two GP practices in Kirklees, showed that a GP would expect to see approximately one whiplash injury every three months or five per year. If a GP has on average 1500 patients that would be 5/1500 and would be approximately 0.4% incidence. This would be a relatively small part of the GP's workload in comparison to the Accident & Emergency doctor. The second consideration was directly related to the fact that the questions the study seeks to

answer are not dependent on the stage of the injury at the time of inclusion to the study.

4.1.2 Recruitment of GP Practices

There were two issues that needed to be taken into account to identify the most appropriate route to access patients for recruitment to the study. The first was concerned with where the patient went for medical advice, and the second was identifying a responsible person who could recruit potential participants to the study. It was recognised that patients with a whiplash injury presented for medical attention in several ways. They may decide to go to the Accident and Emergency department immediately after the accident, either because they consider that they are injured or they may have been advised to go at the scene of the accident by a paramedic or some other person. They may present at the Accident and Emergency department several hours later as they may be experiencing some discomfort, or a friend or relative may have suggested that they be examined. They may decide to go and see their general practitioner (GP) that day or several days later, as they may be having problems that they thought should have resolved or there may be other reasons; for example, an insurance claim cannot be carried out unless they have been medically examined. It was decided that access to patients would be through the GP practice. This was because the GP is the person who is responsible for the care and management of all patients and is notified of all Accident and Emergency attendances made by any of his/her patients and the reason for attendance. The GP was also better placed to make the decision regarding potential participant's eligibility for inclusion in the study as they would have detailed knowledge of their patients.

Between September 2003 and October 2003 nine GP practices across two Primary Care Trusts were approached, to ask if they would assist with patient recruitment and allocate a partner to be responsible for the allocation of patients to the study (see appendix 2). To reflect the diverse nature of general practice the participating practices came from inner city, urban and rural areas of Huddersfield and surrounding villages. They varied in size from a two-GP to a six-GP practice. Five practices agreed to take part in patient recruitment. A meeting was held with each practice to introduce myself, to inform them about the study; explain what their role would be and answer any questions that they might have regarding the study or their role in it. I made a conscious decision to introduce myself as the lead researcher on the study but not make any reference to my professional background unless I was specifically asked about it. The nominated partner was given written information regarding exclusion criteria (see appendix 3) and asked to allocate patients who were suitable for inclusion into the study and to give the potential participant an information pack containing a patient information sheet, an acceptance form and a pre paid envelope to return their acceptance form. The prospective part of the sample involved the allocation of two patients who had presented with a whiplash injury following commencement of the study between November 2003 and August 2004.

The retrospective part of the sample involved the random allocation of three patients from a practice list of patients who had been diagnosed with whiplash injury within the six month period prior to commencement of the study. The practices were also asked to keep a record of the number of patients invited to take part in the study. The personal contact details were not made available to me but were kept by the practice for reference should a follow up letter be required. I maintained contact with each

practice on a monthly basis to ask how many invitations had been sent out until recruitment had been completed. Thank you letters were sent to each practice when recruitment had ended.

4.1.3 Patient Recruitment

An important consideration for interpretative phenomenology is concerned with the homogeneity of the sample due to the small numbers of people being interviewed. This usually means that it is helpful to try and find a closely defined group of people for whom the research question will be significant (Smith, 2003). To try and ensure as much as possible that this was the case, the following exclusion criteria were identified:

- They have been involved in a motor vehicle accident in which a fatality has occurred or other occupants are in a life threatening situation;
- They have sustained other more serious injuries besides their whiplash injury.

These two criteria were aimed at not creating further distress for the participant

- They have a history of mental illness such as schizophrenia ;
- They have a learning difficulty;

These criteria were to lessen the potential for difficulty with communication.

- They have a medical condition such as rheumatoid arthritis, which may affect their injury;
- They have major depression, their symptoms may be aggravated.
- They have a major medical condition;
- They are under eighteen years of age or over sixty five years of age. (The age group 18-65 represented the working age of the population, who may or may

not be in employment. The impact of the injury may be very different when looked at in relation to core roles in society such as occupational role)

- Any patients whom the GP believed would be adversely affected by taking part in the study.

The nominated practices started recruitment for potential patient participants in November 2003. The nominated partner identified potential participants from the practice list and the potential patient participant was sent an information pack. The information pack contained a patient information sheet, an acceptance form and a pre-paid envelope to return their acceptance form (See appendix 4 and 5). When I received a reply from a potential participant I contacted the potential participant by telephone to confirm their intention to take part in the study, answer any initial queries they may have had and arrange a convenient time and place to carry out the first interview (see appendix 6). To maximise recruitment to the study potential patient participants were recruited through a combined approach of retrospective and prospective sampling.

4.1.4 Retrospective recruitment

The retrospective part of the sample involved the selection of participants from the practice list of three patients who had presented with whiplash injury between May and October 2003. A total of fifteen invitations from the participating practices were sent out and by the end of December 2003, I had received a total of one reply. I was quite surprised by this result and to try and increase the numbers of participants it was decided to ask the practices if there were other potential participants on their list who could be invited to take part in the study. A further six invitations were sent out making a total of twenty one. This yielded a further two responses and resulted in a

total of three participants. A slight anomaly occurred at this stage, one of the practice computers identified potential participants whose whiplash injury had occurred in December 2002. This anomaly came to light during the participant's first interview. I decided to include them as participants in the study for two practical reasons. First, it increased the number of participants in the retrospective element of the data set and secondly enabled the effect of whiplash injury to be examined over a longer period of time.

4.1.5 Prospective recruitment

The prospective part of the sample involved the allocation of two or more patients who presented with whiplash injury from November 2003 onwards until recruitment was completed. This stage of recruitment was even slower than I had anticipated. The regular monthly contact with each practice reassured me that the invitations were being sent out. I received my first reply in January and I became more hopeful, however, this was short lived. I had naively thought that recruitment to the study would have been completed by March 2004 as this was the winter period when a lot of car accidents occur. To try and improve the response rate, it was decided to ask the practices if they would send a follow up letter to each potential participant and ask them to indicate their response (see appendix 10). Recruitment of potential patient participants continued until August 2004. A total of fourteen invitations were sent out and resulted in five participants.

4.2 Sample

A total of thirty one potential participants were invited to take part in the study. Eight people agreed to take part (see table 1; page 114). Seventeen people declined to take

part in the study and a further ten gave no response. One reason why the response rate was low might have been due to those people not experiencing the whiplash injury as problematic and therefore they might have felt that they had nothing to contribute. Another reason might concern the length of the study period. The time scale of twelve months and three in depth interviews might have meant it was too big a commitment for them to take on. Only five of the eight participants completed the study (see table 2 page 115). Three participants withdrew from the study after the first interview. Interestingly, two of these, James and Bill, had been recruited retrospectively because of the anomaly that occurred with one of the practices. I think that the timescale between the accident and recruitment to the study might have played a part in their decision not to continue after the first interview. Rav was the third person to withdraw from the study. He was originally invited to take part as a prospective participant but did not respond to the first invitation. He responded to the second invitation and was interviewed six months after he sustained his injury. It is interesting that the three who dropped out were also male and it is possible that gender might have played a part in this.

Table 1 Patient participant characteristics

	Age	Sex	Marital Status	Employment
Martin	38	Male	Married	Self employed
Margaret	40	female	Married	Employed
Bill	45	Male	Married	Self employed
James	39	Male	Married	Employed
Linda	50	female	Divorced	Employed
Rav	18	Male	Single	Unemployed
Steph	40	female	Married	Employed
Hazel	53	female	Married	Employed

Table 2 Break down of patient sample and interviews carried out.

Participant	Duration of time between accident and first interview	First Interview			Second interview 3 months			Telephone interview 6 months			Final interview 1 year		
		site	duration	recorded	Site	duration	recorded	site	Duration	recorded	site	duration	recorded
Steph Prospective	5 weeks	H	27 mins	yes	H	8 mins	yes	U	not known	no	H	5 mins	yes
Margaret Prospective	6 weeks	H	80 mins	yes	H	41 mins	yes	U	not known	no	H	35 mins	yes
Linda Prospective	6 weeks	H	24 mins	yes	H	25 mins	yes	U	not known	no	H	20 mins	yes
Hazel Prospective	6 weeks	H	32 mins	yes	H	40 mins	yes	U	not known	no	H	28 mins	yes
Martin Prospective	5 months	U	40 mins	yes	U	47 mins	yes	U	not known	no	W	15 mins	yes
Rav Retrospective	6 months	U	21 mins	yes	X	X	X	X	X	X	X	X	X
Bill Prospective	14 months	H	45 mins	yes	X	X	X	X	X	X	X	X	X
James Retrospective	15 months	H	not known	failed to record	X	X	X	U	not known	no	X	X	X

H home U university office W workplace X indicates not interviewed

4. 2 1 Participant Profiles

Martin is a 38 year old male and is married with two children. Martin is self employed in the manufacturing industry. His work involves making and fitting blinds. He was interviewed on the 15th December 2003. Martin sustained his whiplash injury in June 2003 and does not consider himself to be recovered as he continues to experience problems from the injury.

Margaret is a 40 year old female and is married with one child. Margaret is employed as a quality assurance technologist. Margaret was interviewed on the 16th January 2004. Margaret has been involved in three RTAs resulting in a whiplash injury on each occasion. The most recent occurrence took place October/ November 2003 time. Margaret does not consider herself to be recovered as she is still experiencing problems from the injury.

Bill is a 45 year old male and is married with two children. Bill is a self employed garage fitter. He was interviewed on 28th February 2004. Bill sustained his whiplash injury in December 2002 and at the time of his interview did not consider himself to be recovered as he has continued to experience problems from his whiplash injury. Bill has also had a previous whiplash injury which resolved within a week. His partner was present during the interview.

James is a 39 year old male and is married with one child. James is employed as a lawyer. James was interviewed on 31 March 2004 and sustained his whiplash injury in November 2002. James describes himself as fully recovered although he is unable to explain why he now experiences some restriction in moving his neck.

Linda is a 50 year old female. Linda is divorced and lives alone. Linda is employed as a teaching assistant. Linda was interviewed on the 6th June 2004 and sustained her whiplash injury in May 2004. Linda does not consider herself to be recovered as she is still experiencing problems from her injury. Linda has had a previous whiplash injury from which she recovered fully.

Rav is an 18 year old single male and lives at home with his family. At the time of his interview, Rav was unemployed. Rav was interviewed on the 11th June 2004 and sustained his whiplash injury in January 2004. Rav was still experiencing problems from his injury and did not consider himself to be recovered.

Steph is a 40 year old female and is married with two teenage children. Steph is employed as a medical secretary. Steph was interviewed on 10th August 2004 and sustained her whiplash injury in July 2004. Steph considered herself to be recovered from her injury, although she still has occasional pains in her neck.

Hazel is a 53 year old female and is married. Hazel is employed and works on a production line. Hazel was interviewed on the 12th August 2004 and sustained her whiplash injury in July 2004. Hazel is still experiencing problems from the injury and does not consider her self to be recovered from the injury.

4.3 Interviewing

Interviews were used to explore participants' experience of whiplash injury. Three semi-structured interviews and one telephone interview were carried out with each participant over a twelve month period. This method was employed as it reflects the

focus of the study i.e. the lived experience of whiplash injury and is widely recognised as being appropriate for several reasons. First, it enables the subjective experience of whiplash injury to unfold, secondly it allows the account to be told in the individual's own words (Marshall and Rossman, 1999:61). Finally, it is useful when the range of responses is not known in advance (Murphy et al, 1998). The use of in-depth interviews allows a greater exploration of the participants' lived experience as it provides them with the opportunity to talk freely about their experiences (King, 2004). This style of interviewing also facilitates the development of trust and rapport between researcher and participant (Johnson, 2002). The in-depth interview also 'emphasises the expertise of the interviewee' (Hansen, 2006:100) thereby empowering participants in the exploration of their experience. When carrying out in-depth interview, it is recommended that the researcher begins the interview by putting the participants at ease by using a general introduction before introducing more specific questions (King, 2004; Smith, 2003).

4.3.1 Developing the patient interview schedule

There were two aspects of my own experience that were influential in the development of the interview schedule. The first came from my own personal experience of having a whiplash injury and the second was my reflecting on how different the medical understanding of the patient's complaint might be if lived experience was taken into account. Prilleltensky and Prilleltensky (2003: 203) suggest that a 'critical appraisal' of the situation through attention to the 'lived experience' might also make a difference to the way treatments might be 'prescribed and accessed'. A total of three interview schedules were developed for use at different stages of this study.

First Interview Schedule

The first schedule (see appendix 11) was used in the first interview and contained five sections with a list of prompts. These were: the accident, the experience of healthcare, psychological experience, social situation and recovery.

Second Interview & Final Schedule

The second schedule (see appendix 12) differed from the first one as the section about the accident was omitted. The sections pertaining to the experience of healthcare, psychological experience, social situation and recovery were retained. This schedule was used at the second interview which took place three months after the first interview and the final interview at twelve months.

Telephone Interview Schedule

This schedule reflected the purpose of maintaining contact with the participant and to identifies any changes that might have taken place since the last interview (see appendix 13). This schedule was used when the participant had been in the study for six months.

4.3.2 Piloting the patient interview schedules

I piloted the interview schedules on friends and colleagues who were known to have had a whiplash injury. Four interviews were carried out. These interviews were tape-recorded and I asked each person what they thought about the questions and the interview. The feedback from the first interview was that the questions were alright but that I had focused too much on symptoms. I found this extremely helpful as it made me aware of my natural way of interviewing patients and my tendency to focus

on symptoms. This was when I made the decision that I would use the interview schedule as a mechanism to stop me going off in a medically orientated direction. The schedule was amended to reflect this comment (see appendix 10 for semi-structured interview schedule). Feedback from the other interviewees confirmed they felt at ease with the questions and that the questions were not considered to be intrusive.

4.3.3 Interview Setting

Before conducting the interview, it is important to consider the environment where the interview will take place. Factors such as safety, confidentiality, formality and accessibility to the interview setting need to be considered. These are important if the participant is to feel relaxed enough to talk about their personal experience. I gave the participants the opportunity to be interviewed either in their own home or at the university. Two of the participants chose to be interviewed at the university; the remainder chose to be interviewed in their own home. The home environment is one where I personally feel at ease having spent much of my professional life working with families in their own homes.

4.3.4 Interview process

I introduced myself to each participant as a researcher and at this point I was usually offered a drink by the participant. I always accepted this offer as it allowed the introduction and any awkwardness that might be experienced due to the strangeness of the situation to settle down. The interview began with an explanation about the purpose of the research and its anticipated outcomes and their consent to take part in the study and to record the interview was obtained. The participant was also informed that they could stop or even withdraw from the interview at any time and there was no

obligation to answer all the questions if they felt it was not appropriate or they did not want to share that information with me. Once the formality of introductions was over I began recording and used the interview schedule to conduct the interview (see appendix 11).

During this time, I observed the participant's facial expressions and paid attention to their body language. This was for two reasons: first, I wanted to ensure that the participant was not becoming unduly distressed with what they were talking about; second, I wanted to take note of the bodily aspect of communication. The effect of the whiplash injury could be observed whilst the participant was relating their account, and bodily movements were used to demonstrate how their injury had affected them and as way of conveying meaning. I had also become aware from counsellor training of the potential for bodily communication and empathy between counsellor and client and could see no reason why this should not also apply to interviewer and participant. Finlay (2006) draws attention to the embodied nature of the interview and that by probing our own embodied responses, it is possible to open up rich understandings that need to be underpinned by 'embodied reflexivity'. Before the interview was completed the participant was given the opportunity to ask any questions or to add anything else they might want to say. At the end of the interview I informed them that I would give them a copy of their interview transcript once it had been transcribed and that they could read and make comments on the material. I also gave them the opportunity to either make the next appointment now or said that I could phone to make the appointment nearer the time of the next interview. They all asked me to phone nearer the time. After thanking them for their time and ensuring they had my contact details should they need to contact me, the interview was completed.

4.3.5 After the interview

When I got back in the car, I telephoned a member of the supervision team to let them know the interview had been completed and that I was alright. I recorded my general impressions of the interview when I arrived back at base whilst the interview was still fresh in my mind. This was because most of the interviews took place during the evening. Once I arrived back I would listen to the recording to make sure it was alright and then place the material in a locked filing cabinet for safety. The habit of listening to the recording on arrival back to base proved to be good practice, as unfortunately for me, one of my interviews failed to record. This meant I had to try and write down from memory what had taken place during the interview.

4.4 Analysis

There were three stages to the process of phenomenological data analysis in this study. First, the interviews were transcribed by myself verbatim. Van Manen (1990:99) describes this as a 'collaborative hermeneutic conversation'. Second, was the utilisation of template analysis. Transcriptions were read with every effort being made by me to bracket my own experience to identify the implicit meanings in the text. The final stage was describing the phenomenon through the art of writing and rewriting.

The interview data were transcribed verbatim and identifying data were removed from the transcripts. This process was carried out with each interview. This stage is generally recognised as being time-consuming, Smith (2005) suggests it takes between five and eight hours to transcribe a one hour interview. I found this time

scale was more than doubled due to the physical difficulties that I experienced whilst transcribing, and this led me to carry out the transcribing in short but frequent episodes. The whole interview was transcribed including the questions asked (see appendix 11 and 12). The level of detail required for template analysis is similar to that of interpretive phenomenological analysis which is generally at a semantic level (Smith 2003). This means that all the words including false starts, significant pauses, interruptions, laughs are worth recording. This contrasts with the significant detail and conventions that are required for conversation analysis. A margin was left on both sides of the transcript for analytic comments to be made. I also found that whilst I was listening to the verbal descriptions and re-reading the transcriptions to check their accuracy, I began to have thoughts around the data and what it might mean. However, it is important at this stage in the process to hold these thoughts in mind without specifically acting on them. This meant that I made a note of them.

4.4.1 Analysis: Template analysis

When carrying out Template Analysis (TA) it is customary to wait until there are four or five interview transcripts available before commencing analysis. This can be quite a frustrating stage if, like me, you have to wait for several months before there are enough interviews to begin developing the template. The process begins with the selection of a transcript to start the initial development of the template. It is usual to give a copy of the selected transcript to another person or member of the team and then meet up to compare preliminary coding and themes before going on to produce the initial template. The purpose of comparing preliminary coding is not about checking reliability, it is about challenging any preconceptions that might limit my analysis. I did this with one of my supervisors and then within supervision.

The transcribed interviews became the phenomenological texts upon which the analysis was conducted. The transcripts were analysed with the aim of explicating the different meanings the experience had for each person and to identify how that experience might be influenced through their first encounter with healthcare providers as represented by doctors. As discussed in chapter three, TA was used to organise the findings.

4.4.2 Developing the template

I selected Margaret's transcript to begin the analysis. I chose this transcript for two reasons. First, it was a rich transcript with a lot of interesting aspects such as her level of knowledge on whiplash injury, the types of treatment that might be helpful, her experience of the physical changes and what this meant for her lived experience.

Second was a pragmatic consideration: the interviews were slow to come in. I read the selected transcript through twice before I began summarising the interview as this helps with familiarisation of the data and makes the material more manageable. I used the interview schedule to assist in structuring the initial template by identifying a-priori codes and themes. I was especially interested in what took place during the consultation and the type of treatment the participant had. After this I returned to the transcript and added annotations and simple descriptive coding. Following the preliminary identification of codes and themes, I met with my supervisor to compare coding before I continued with the development of the first template. Following this meeting, I returned to the text and provided more interpretation by clustering codes together and ascribing meaning to each group. This started the process of hierarchical coding, with general codes leading to more specific codes until production of the initial template had been completed.

My first attempt at production of the template was based solely on Margaret's interview and I produced a template which was mainly descriptive and medically orientated (see table 3 page 126 for summarised template; see appendix 15 for full template). This part of the template development was instrumental in assisting me to acknowledge and also let go of my natural way of looking at the phenomenon to allow new meanings to emerge. According to Morse (2002:435) 'interventions arise out of everyday practice' and in that sense the descriptive content from the patient's experience has a pivotal role in informing the development of potential interventions in the management of whiplash injury. One of the problems with the initial template comes from the production of large numbers of codes and themes. Some of the themes overlapped and came together to form a small cluster. For example, pain was a theme with multiple codes as each reference to pain was given a different code to show where the pain was. Pain management had each reference to medication being coded, whether or not it was successful, and other treatments of pain such as keep warm were coded. Pain also had codes for duration and intensity of pain.

Table 3: Summarised initial template (patients)

Theme	Lower level theme
History of whiplash	Current incident Chronology of symptoms Previous incidents
Current / Recent symptoms	Headache Back pain twinges Neck stiffness Initial dismissal of symptoms
Seeking help	2-3 days after accident Healthcare professional <ul style="list-style-type: none"> • GP <ul style="list-style-type: none"> - Basic examination • Osteopath considered going back • Physiotherapist <ul style="list-style-type: none"> - not option • Acupuncturist <ul style="list-style-type: none"> - not option
Knowledge of Whiplash	Familiarity with symptoms Knew what to avoid <ul style="list-style-type: none"> • Certain movements Aware of risks <ul style="list-style-type: none"> • Rest, not go to bed
Self Management	Manage pain <ul style="list-style-type: none"> • Over the counter medication • Non medical <ul style="list-style-type: none"> - Hot baths - Wheat bags Avoid draughts <ul style="list-style-type: none"> • Wrap up, use scarves Exercises Being sensible Personal responsibility
Other service providers	Physiotherapist Osteopath Alexander - therapist Accessibility of services <ul style="list-style-type: none"> • NHS long waiting list • Financial implications
What will help	More information from GP Access to other services Advice on self care

At this point I went back to the transcript and re-immersed myself in the data. I re-examined each line and sentence as I tried to develop new insights into the phenomena and grasp an understanding of the participants' experiences. This highlighted the need to create new codes and merge or delete existing codes and to create new themes in the template. For example, pain was a theme with multiple codes as each reference to pain was given a different code to show which part of the body was affected. Pain management had each reference to medication being coded, whether or not it was successful. This meant that paracetamol, which is an over the counter medication, was a code, diclofenac, which was prescribed medication, was a code and even a hot water bottle that was used to gain relief from pain was included in this. As I reflected on this, I realised that it did not matter if the treatment was prescribed or not it was the relief of pain that was important. Pain relief was also just one aspect of the experience of pain and this was not necessarily a key aspect. The experience of pain was a better description of both the effect of the symptom, pain and the management of pain.

From here, the template continued to be developed. All remaining transcripts were analysed through the process of coding using the initial template. The initial template was revised as a result of looking at the other transcripts. Applying the initial template showed that the existing themes and coding needed to be readjusted. This meant that there was a continuous cycle of codes and themes being created, deleted or merged, until the final template was produced (see table 4; page 128). At this point, it is necessary to reflect critically on the choices being made by constantly holding the identified theme against the context of the story being told and ask: does this story fit the text as a whole? Is there a different way that the interpretation might be told?

Table 4: Final template (patients)

Theme	Lower level theme
The healthcare experience	Identifying the problem <ul style="list-style-type: none"> • Pain • Stiffness Treatment <ul style="list-style-type: none"> • NHS treatment • Other providers • Chiropractor • Physiotherapist Information whiplash injury Participant evaluation of health care
Embodiment	Disrupted body movement <ul style="list-style-type: none"> • Change in posture • Loss of movement Experience of pain <ul style="list-style-type: none"> • Severity of pain • Pain management Disruption to lifestyle Changing sense of self
Making sense of their injury	Physical cause Comparison <ul style="list-style-type: none"> • With other injuries • Other people with same injury • Worst case scenario Personal responsibility Search for knowledge
Patient as expert	<ul style="list-style-type: none"> • Formal sources <ul style="list-style-type: none"> - Different professionals • Informal sources <ul style="list-style-type: none"> - Internet - Social networks
Whiplash: a ‘minor injury’	Medical classification

A strength of qualitative analysis is the way it enables new meanings and understanding of phenomena such as whiplash injury to emerge from the data that would otherwise remain inaccessible. Reflecting on the pain aspect of the injury I became aware that that experience of pain from whiplash injury was also implicated

in the disruption to movement. I made a conscious decision not to code pain and disruption to movement together as they felt different. Doing this led to the theme embodiment and the development of another way of making sense of the experience of symptoms from whiplash injury. The final template provided me with a structure to my data that I used to write up my findings. I have also taken the decision not to respond to the findings in the findings chapters.

Chapter Five: The patients' case studies

Two methods of presenting the findings will be used. These are case studies and thematic analysis. The reason behind this is the point of being holistic as using a thematic based analysis will distract from looking at the account as a whole and using the two methods will balance that. Chapter five will also contain some of my personal reflections.

Having described the method used to recruit patient participants to the study I will now go on to present the individual case studies that were produced alongside the template analysis of the patient interviews. This was done in order to demonstrate the context and unique experience of sustaining a whiplash injury and its subsequent effects over time, and to identify the strands that draw them together as a shared experience. Two methods of presenting the findings will be used. The case studies also contain some of my reflections about the interviews and the second method will use a thematic representation. I will begin with the presentation of individual case studies and then go on to look at the thematic analysis of the data in chapter six.

5.1 Martin: *How will I manage?*

This was my first interview and as I went to meet Martin I felt nervous and excited at the same time. I had overcome so many obstacles to get to this position and myriad thoughts raced through my mind, such as the practicalities of recording an interview and whether the interview schedule would be ok. Martin was friendly and easy to relate to and by the time we had walked from the reception area to the interview room the nervousness I felt began to settle. The start of Martin's second interview three

months later was very different to the others: it felt as if it could have been a counselling or health interview due to Martin's strong emotional feelings that surfaced in response to my asking 'how has it been since we last met?' Martin had a plastic drinks bottle in his hand, and he kept turning this and at times he banged it on the table whilst he was speaking as if to emphasise what he had just said.

Martin talked about the accident and how he regarded it as just one of those things that happen. He was a front seat passenger and described himself as being lucky on that day, as unusually for him he had put his seat belt on, otherwise, he might have gone through the windscreen. At the time of the accident he considered himself to be unhurt and recalled saying to the police 'that he was fine', as there were no obvious injuries. Martin first went to see the doctor two days after the accident because he had woken up to find he could not move properly. He described this as 'everything had just locked up'. He could not move his arms properly nor move his head in any direction. The feeling of locking up made him panic and seek medical help. He was fearful as he did not know what was happening to him or how he would be able to manage the business.

The doctor told Martin that he had definitely got a whiplash injury and was prescribed some mild painkillers for his pain. Martin was also given a leaflet and advised to do exercises and said that the doctor had told him 'just try this, as it'll make it a lot easier for a physiotherapist because you will have done half of it for them'. Martin could not manage to do the exercises because it was too painful for him. Martin found the injury to be so painful that he not only returned to see his doctor but he also went to see a chiropractor. Martin found the treatment from the chiropractor to be more helpful than

that the treatment his doctor could provide. Martin continues to attend his chiropractor periodically to help him manage his whiplash injury and at £30 a time regards the money as well spent.

The whiplash injury affected Martin's daily life in many ways. Martin was unable to carry out his normal work activity as he couldn't move properly or lift heavy tools. As he is self employed in a new business, much of the day to day work fell to his business partner. For at least seven weeks Martin sat in the office doing what he could, such as paperwork and answering the phone. While telling me this he demonstrated how far he could raise his arms. The tasks that involve sitting and restricted movement for long periods of time appeared problematic. Martin found that he could sit for periods of around 30 minutes then he would have to get up and move about. During the interviews, I noticed that Martin would move about in the chair and this was more than I would have expected. Martin had begun to consider the possibility that his job was making his condition worse because of all the bending and lifting he had to do. For a short time he considered changing the kind of work he did but this was not really an option. Martin also found that the injury impacted on his life at home. He could not settle to do work on the computer or do his usual jobs around the home. As time went on he found that other jobs that he normally did, like the gardening, were also affected and he began to feel as if he had lost his independence. This loss of independence meant he had to ask people for help with jobs that were heavy or involved lifting. Martin has two young children and the effect of the whiplash injury meant that he could no longer engage in what he regarded as the 'rough and tumble' of children's play. Their time together became quieter and more sedate.

Martin found the painful aspect of whiplash injury was in many ways more problematic for him than the stiffness and restricted movement:

When it first happened when it all kicked in I was in that much pain it nearly drove me to tears and I'm not a crying type of person but I was in that much pain. It really was bad.

When the pain was at its worst he described it as 'beyond 10 on a scale of 1-10'. Using a scale of 1-10 to rate the intensity of the pain Martin described the intensity of his pain as '5-6' during his first interview. At the final interview Martin was aware that pain had become a constant companion in that it was always present. He rated this constant presence of pain as a '1'. Martin would ignore this low level of pain until it increased in intensity when he would have no choice other than to take notice and do something about it. The action he took could be something as simple as moving about or stretching, taking pain relief or returning for a treatment session with his chiropractor. The pain and discomfort from the injury impacted on Martin's ability to get a good night's sleep and his attempts to get comfortable in bed would often end up with his partner's sleep also being interrupted. Martin tried to manage this situation by going downstairs to sleep on the floor as it seemed the only way that he could get comfortable. This puzzled Martin as he said that he had an orthopaedic mattress on his bed. The lack of sleep produced a change in Martin's manner and he described himself as 'being like a bear with a sore head at least in the morning'. It would take him a few hours to recover his normal cheery disposition. At his final interview, Martin revealed that he has continued to experience problems with the lack of sleep but feels that he has adapted to this and can cope with it.

Martin was claiming compensation, but did not know whether it would be successful or not, as the driver of the other vehicle was not insured. The injury had a financial

impact for him in terms of income for the business and treatment costs. Martin experienced the process of claiming compensation and the uncertainty of not knowing what the outcome would be as stressful. His compensation claim was settled before his final interview. Martin said that the money he received in compensation did not fully recompense his losses as his business loss was not taken into account.

Martin's driving behaviour changed after the accident. He had become more cautious and was aware of the need to keep a distance between cars. This was something that he had not been conscious of before the accident. Before the accident, he described himself as 'the boy racer, now I'm the old man in the car'. He laughed about this as if to cover up this change that he detected in himself. During Martin's second interview he described how being in the car had become more stressful. This had become apparent when he had started to drive to customer's houses instead of staying in the office. At that time he would have been happy never to drive again and was surprised that he felt that way. In Martin's words:

I get frustrated. I think to myself "bloody hell all that because of that stupid woman". [Martin takes a deep breath and laughs] So that's it basically it just comes back to you, it just doesn't leave you. [Silence] I just feel sorry for the people that survive the worst crashes as they'll be constantly reliving it, I would imagine so. If I'm just reliving the little one I would imagine these other people will be reliving the accident all the time and I'm not surprised they have to go and see a psychiatrist or [Martin laughs] anything like that.

Martin's experience of reliving the accident suddenly changed the distinction between a minor and a serious car accident. It was meaningless to differentiate between the two. That felt like a significant moment as Martin seemed to settle down and I could see how the tension he showed in his body disappeared as he sat back and relaxed in the chair. At the final interview, Martin had regained his confidence in the car and felt

alright when he was driving, although he continued to keep a safe distance from other cars.

Eighteen months after the accident, Martin does not consider himself to be recovered from his injury although it is not as disruptive as in the early months when he could do very little. Martin continues to experience pain which he says 'is there all the time'. Martin had recently seen a consultant as part of the medical legal process and was told it would be eighteen months before he recovered. Martin was not sure whether the consultant meant eighteen months from the accident or eighteen months from the medical legal assessment which would be 2007. Martin said 'I don't feel as if I'll ever be right' and has taken a stoic attitude towards his injury: 'I'll just have to get on with it the best I can' and he hopes that it will eventually resolve.

5.2 Margaret: *The expert now*

I quickly established a rapport with Margaret who had much to say about her experience from the outset. Margaret came across as an expert on whiplash injury and at times I felt as though she was trying to draw me into her experience and take her side.

Margaret spoke with ease about this latest accident (her third accident) which she described as a minor incident. The collision had taken place in a car park. The incident happened as a result of herself and the other driver driving out of the parking spaces into each other. At the time Margaret thought she would be lucky and not get a whiplash injury like she had done with two previous accidents. The reason why Margaret thought this was because she was moving slowly and her car was not

damaged whilst the other car needed a new wing. Margaret recognised the headaches and twinges starting in her back and then stiffness with turning her head as the familiar signs of whiplash injury. She hoped it would settle down but it was about two days later when she had trouble turning her head to reverse the car and had difficulty in doing the usual movements that she knew it was ‘whiplash’ again:

*Things that you can normally do that just require a head turn,
the whole of the body’s got to go with it.*

The verbal description of changes in posture was accompanied by a physical demonstration of how the body folds into itself. Margaret’s suspicion that she had a whiplash injury was confirmed by her doctor. Margaret was taken through some basic exercises and prescribed medication. Unfortunately for Margaret she had a reaction to the anti-inflammatory medication and had to rely on hot baths and ‘being sensible’. By this she meant keeping warm, avoiding draughts and trying to take it easy but keep moving. Margaret felt that the care offered was poor, as apart from the exercises, she was not told anything about the injury or given any guidance on self help. As far as Margaret was concerned, the reason she was not given any information about whiplash injury could not be explained by the doctor knowing that she had had a previous whiplash injury and added that she had never got much advice before on how to manage the injury. Margaret felt that because of her previous experiences of having a whiplash injury and the fact that that she had learnt a lot from the physiotherapist and Alexander therapist, she was able to manage the injury herself. This was achieved by putting into practice the strategies she had learnt. She stressed the trial and error nature of finding out what works the best.

Margaret's daily life was affected by the whiplash injury in many ways. At work Margaret was unable to carry out her normal work activities and was dependent on the goodwill of colleagues and her manager to help her stay at work. The manager allowed her to take time out and lie down when the pain and stiffness felt unbearable whilst her colleagues did the lifting and carrying. Margaret also avoided the driving aspect of her work for about ten days. Margaret felt that she was unable to take any sick leave due to the constraints of a new policy that had been introduced governing sickness absence by the company she worked for. The change in policy had led to her and other staff feeling worried that if they had to take sick leave for any reason it might result in them losing their job. 'In theory if we had six half-days off sick in a year we could be sacked'. This meant it was important for her to try and remain at work and she was extremely grateful that she had supportive colleagues.

At home, her partner and son did the lifting and carrying associated with household tasks. They had to help with the shopping and do the tasks that involved body movements of twisting or stretching like loading the washing machine, cleaning the windows or hanging the washing. Margaret was unable to take their dog as usual for his nightly walk as he was a large dog and when he pulled on the lead she could not hold on to him. Margaret has a ten year old son who she would take swimming and she had to stop this shared activity as she could only do breaststroke. This is a swimming stroke that can increase pain and tension on muscles especially if the face is out of the water. Margaret wears contact lenses and does not like to have her face in the water so was unable to accommodate the change needed to maintain this activity with her son. Margaret found that simple activities like standing at the football match watching her son play created difficulties as she could not stand for long periods of

time and the cold exacerbated the pain and stiffness. This made Margaret feel guilty as she felt her son suffered as a result of her injury. Margaret did not like having to plan in advance everything that she wanted to do with her family just so she could manage her situation and she was sensitive to the fact that some of the strategies she used, such as taking a chair to sit on whilst watching her son play football, would draw attention to her situation and make it public. Not being able to do things spontaneously or activities that her friends could do made her feel much older than her years:

In these days when you are forty it is like years ago being thirty. I should be very fit and active, I shouldn't be as fat as I am because I've put a stone and a half on. I shouldn't be as big as I am. I should be still be enjoying a lot of physical activity when I'm not. I feel quite sedentary [Frances softly right, yes] I should be like this when I'm sixty not when I'm forty.

The injury impacted greatly on Margaret's ability to get a good night's sleep. The lack of sleep made her become more moody and irritable with everybody. The lack of sleep accounted for the fact that she had started 'growling with everybody' and this change in her led to the situation that she described as the 'family half hated me'. Even her colleagues at work could tell by the look on her face that she had not got any sleep again and ignored her until she came round. Margaret went to bed earlier than usual to try and get the sleep she needed to remain civil and her family had to leave her alone:

I'm asleep: you don't wake me up under any circumstance. You know the house had to be on fire. No matter who phoned, my mum could ring wanting to speak to me, it was 'she's actually in bed and she's asleep'. So everyone knew, like, don't disturb her.

Margaret's restlessness also disturbed her partner's sleep. Margaret used varying methods to aid sleep such as lavender oil in a warm bath, milky drinks and a warm wheat bag in the middle of the night. Margaret described the pain and discomfort she experienced at the first interview as being '4-5' in response to my question. She also felt that because of her expertise she had managed her pain quite well. However, she did feel that she would have used acupuncture again if it had been an available option to her as an NHS patient as it had worked well with a previous injury.

Margaret's driving behaviour did not change with this accident. Her driving behaviour changed after a previous accident into what she described as 'a cautious driver'. This meant that she liked to leave a lot of space between her car and others. She became aware of this change when a friend passed a comment about it and Margaret said that she is 'always watching other cars to make sure they don't pull out front her'. Margaret also has to plan more stops when taking longer journeys as she becomes physically uncomfortable after fifteen to twenty minutes of being in the car.

Margaret is not claiming compensation for this accident as it was a company car and the insurance did not cover the driver for injury. Margaret did take legal advice and was informed that she could make a private claim which would be a 50-50 claim. This meant that she would only be able to recover half of any financial costs related to this accident. Based on her past experience of the time taken and stress produced by making a claim she decided that it was not worth the extra effort and hoped that her financial outlay was not too considerable this time. She felt that she knew enough to be able to manage her condition herself and limit any expenses involved with treatment.

At the final interview Margaret did not consider herself to be recovered from her whiplash injury and thinks that it is like having arthritis. She said ‘you don’t ever fully recover; you just learn to manage it’. Learning to manage the injury involves a process of trial and error until you find out what works for you. Margaret has never fully recovered from her previous injuries as she continues to experience pain and has problems with posture and movements.

5.3 Bill: ‘Mr Grumpy’

This interview differed from the others as Bill requested that his partner, Mary, be present throughout the interview. At first I felt unsure about this, but could see no reason why it would cause a problem and said it would be satisfactory. With his partner’s presence, Bill became more relaxed as he began to answer my questions. Mary’s presence enhanced the interview by supporting Bill as he struggled to tell me about his experience and she offered insights into the impact felt by the family. This was the only interview carried out with Bill. Bill’s accident had occurred fourteen months prior to the interview.

Bill recalled how a truck had run into the back of his vehicle whilst waiting at a junction. He was thankful that he had been in his pickup when the truck hit him and not a car as he said ‘I would have been creamed’. Bill went to an Accident and Emergency (A&E) department the same day as his neck, shoulders and back began to stiffen up soon after the accident. Bill continued to stiffen up and about three days later went to see his GP as he could not move properly. At the A&E department he

was advised by the doctor to take paracetamol and was given a leaflet on neck exercises. Bill's own GP told him he needed physiotherapy but the NHS had a three to six month waiting period for a non-urgent referral and prescribed stronger pain relief. Bill was also advised to support his neck when lying down, to rest but keep moving, to avoid heavy lifting and to refrain from work.

When asked about his experience of healthcare Bill laughed [ironically] as he recalled how the A&E doctor, after feeling his neck said 'Yeah it's whiplash, take paracetamol and you'll be alright'. Bill felt that he had not been examined as they did not take an x-ray and said 'I waited three hours and was in and out in 5 minutes'. Bill said that his GP had responded to his concerns and he also used planned follow up appointments to review his condition. Whilst Bill could understand the NHS defining conditions as non urgent, he saw himself as being an urgent case as he was unable to move properly or do any work. Bill's GP explained to him the mechanics of his injury which helped him to understand what had happened to his body. The physiotherapist, who he saw privately over a period of six weeks, used different treatments aimed at relieving the pain and improving his body movements and also advised him on how to manage on his return to work.

The whiplash injury affected Bill's life in many ways and he described it as 'life being brought to a standstill'. This was because everything that he was doing stopped through the effects of the pain and restricted body movements. The pain he experienced was '9' or '10' on a scale of 1-10 and he needed regular pain relief to make it tolerable. Bill found the treatments from the physiotherapist helped him the most as he was then able to move more freely for several hours afterwards. Bill found

his regular sleep pattern was disturbed for two reasons. The first was due to the pain and discomfort that he experienced and the second was because he had started to worry about his business and the finances as he could not work. Being a self employed one-man business, meant there were no colleagues to support him at work and he did not qualify for any financial help such as incapacity benefit. Fourteen months after he first had his whiplash injury, there are still occasions when Bill has to get assistance from elsewhere to help with some of the work, as there are certain jobs that he can no longer do.

The injury put a strain on the whole family as they struggled to manage the effects of Bill's injury. Mary had thought about going out to work to help them financially but the physical effect of the injury meant that Bill could not even lift their little girl and was unable to manage the movements required to change a nappy. All the work that was previously shared within the family fell to Mary and their eldest son. Bill found that he could not even walk the dog. Bill was renovating the house at the time and he had to stop doing the renovations, so they lived in a mess. He became irritable and depressed because of the frustration of his situation, and the family named him 'Mr Grumpy'.

Bill found that he had changed from feeling at ease in the car to being very nervous in the car, especially when passing where the accident had happened and he had also become nervous as a passenger. Wendy described Bill as 'having got back on the horse'. He still finds himself becoming edgy at junctions and explained that it is like he is waiting for somebody to run into the back of him. He also gets nervous and on edge when ever there is a possibility of a car running into the back of his car. This is

particularly noticeable if he has to stop in a queue of traffic as he would have nowhere to go if an approaching vehicle did not stop.

Bill claimed compensation for which he received the minimum settlement of £2000. He felt this amount was not fair as he thought that it did not reflect either his actual losses or the stress that he suffered as a result of the accident. He told me that he did not even recover his physiotherapy expenses which were around £600 as his solicitor lost the receipts.

Bill did not consider himself to be fully recovered from his injury and described himself as ninety percent recovered fourteen months later. His reason for saying this is because he still has ongoing problems with certain body movements or positions, for example when he bends over, his back goes, or if he is leaning back or stretching, his neck is problematic. This means that he is still very aware of what he is doing and he emphasises the fact that he has to be very careful at work. He does feel that he manages his injury quite well by exercising caution in what he does, by using a warm wheat bag to relieve any pain and discomfort and by stopping what he is doing and taking it easy instead of ignoring any pain and carrying on with what he might be doing.

5.4 James: *Now I know what it feels like*

Whilst James was open and friendly in manner I found him difficult to interview and he appeared ambivalent towards taking part in the study. He wanted to be helpful but felt he was wasting time as he had nothing to offer. James was forceful and

authoritative in his delivery of his responses and for some reason I felt very unsure of myself whilst asking questions. I felt that the interview schedule became like a prop that enabled me to feel secure in the interview. I could not make sense of what was taking place and why I felt like I did until we reached the section on compensation when he said 'I'll have to come clean. I wasn't exactly truthful with you when I said I worked in 'IT'. I do use computers, but I'm actually a defence lawyer'. This revelation also explained the tirade about whiplash injuries and spurious claims that occurred as we went through the consenting process. This was the only face to face interview carried out with James. He was happy to have telephone contact, but I was unable to secure a further face to face interview. I was very disappointed about this especially as the recorder failed to record the first interview.

James told me how a car ran into the back of his car when he was at a roundabout, and described it as low impact. He considered himself unhurt at the time and was annoyed over the inconvenience the accident caused him. He was shocked when he awoke the next day and found he could not move his head and had restricted neck movements. He went to see his doctor as his immediate thoughts about the cause of his predicament were of a spinal injury. James was told he had a whiplash injury but felt he was not given any treatment. He was told he could have physiotherapy if he thought he needed it but there was a waiting list for it. James was bemused by the fact that he had to make the decision on whether or not he thought he needed physiotherapy. As there was a waiting list James had private physiotherapy as he thought that if you need physiotherapy as a treatment then it was needed straightaway and not months later.

James viewed his whiplash injury as an inconvenience at the time because the injury affected his neck. James was able to continue with his normal daily activities, with the exception of going to the gym. James did experience problems with using the computer at work as it made his neck hurt more but other than that he was able to carry on as normal and did not take any sick leave. James was physically demonstrating his neck movements when he stopped and said 'I don't know why I'm showing this it's not as if it's being videoed'. James had been more concerned about his loss of neck movement rather than the pain which he described as low, rating it as a '3'.

James does not feel that the accident has changed his driving behaviour in any way other than to make him more aware of vehicles behind him. He feels the same in the car as he did before the accident. He pointed out that he could no longer turn his head as far as he used to do when looking to see what is behind him.

James claimed compensation for his injury as he was annoyed about the inconvenience the accident caused and because the driver of the other car did not apologise. He knows that insurance companies tell you not to admit fault or to apologise but he feels this attitude makes the situation worse. He also saw the process as personal research; he wondered what it was like to be on the other side and have to go through the system. The experience of having a whiplash injury changed his previously held view about whiplash injury and said 'a whiplash injury is a proper injury only it can't be seen like a broken leg and you should be compensated for your pain and suffering'.

James considered himself to be fully recovered about three weeks after the accident, as he could do all that he did before the accident. As far as he was concerned, the main effect of his injury related to his health insurance. He explained that his neck will no longer be covered as it had become a pre-existing condition and feels that he was being penalised for something that was not his fault. James now has less movement in his neck but otherwise feels no different to his pre-accident state and explained this by saying 'I could not say if the reduced movement was because of the accident or not. It might have happened anyway'.

5.5 Linda: *They said it was nothing, but it is*

Linda was quite nervous during the interview and felt that she had nothing to offer and would be wasting my time. I used the process of obtaining consent to help her feel at ease and emphasised that what she had to say would be of value. The interview started tentatively but Linda quickly settled as she began to tell me about her experience.

Linda told me that her accident happened when she was stopping at a red light and the car behind, instead of stopping behind her, continued and went into the back of her car. She was annoyed about the accident because of the inconvenience and the stress caused by the financial outlay required for repairing the car and reclaiming the money back when it was not even her fault. At the time of the accident she thought she was ok, however, a few hours later her neck began to hurt and then her back started to ache. This continued throughout the evening and led to her making an appointment with her doctor.

According to the doctor, it was ‘a classic case of whiplash and they didn’t use collars anymore’ and gave her exercises to do instead. She was shown how to do the exercises and told to ‘do them regularly and not keep still because of the pain’. Linda was told what she needed to get for her pain, and to buy it from the chemist as that would be cheaper. She was also advised to take tablets for the first two weeks and then to use the pain relieving ointment. Linda felt that her injury was treated like ‘something and nothing’. It was an everyday occurrence, you just have to go away and get on with it. Linda said, ‘I was so shocked from the accident as well and upset and it was probably treated like you’d cut your finger’.

The whiplash injury affected Linda’s life through the restriction she experienced with her bodily movements and normal postures. The injury also disturbed her sleep as she could no longer sleep in her usual position because of the pain in her neck and lower back. This also prevented her from finding more comfortable positions. Movements made during sleep would also wake her up. Linda enjoys running and for a couple of weeks was unable to run at all but has been able to start running again as she does not have to turn or twist. Linda did not take any sick leave from work as her work does not involve carrying or lifting, and she found that if she restricted her movements when getting up, sitting down, or doing things with the children, at the school where she worked, she was able to manage. For example, she would position herself so she could see all the children instead of having to turn when speaking to a child. Linda was surprised when she found that several months later, certain household tasks like cleaning the bathroom tiles caused her problems and certain movements continued to be problematic. For example, when watching a television screen she has to sit facing it straight on and not look at it by turning her head from the side otherwise it would

cause pain. Linda described the pain she experienced from her injury as tolerable, which she rated as '5', but certain movements could increase the intensity of the pain up to '8'. Linda does not like taking painkillers and attempts to manage the pain through restriction of movement and using different positions. This was evident throughout the first two interviews where Linda kept her head very still. Before the final interview Linda had been to see a physiotherapist and was using exercises to try and improve movement and lessen the pain. She described the pain as 'discomfort and crunches rather than pain'. By crunches she meant the "creaking and cracking" of the bones in her neck.

Initially, Linda described herself as still being a confident driver and her driving behaviour had not changed. Over the time of the interviews, Linda, who still describes herself as a confident driver, has found her driving behaviour has changed. She finds she is always thinking about the accident and has become nervous in the car. The change in driving is related to when she has to brake or slow down in traffic as she has become fearful that the other cars are going to go into the back of her car. Linda now finds herself braking earlier than she should do in the hope that the car behind will see her brake lights and respond by stopping and not going into the back of her car.

Linda found herself claiming compensation because she put on the insurance claim form that both her and her passenger sustained an injury. This resulted in the claim automatically being transferred to the legal claims department. Linda felt angry about this as she had not actively sought to claim compensation and she also found the process quite stressful. She does not like filling in forms. When Linda was still having

problems with her movements several months after the accident she was referred to a physiotherapist for treatment by the insurer's solicitor. At that point, she felt as though her injury had finally been taken seriously and that it wasn't 'something and nothing'.

A year after the injury, Linda does not see herself as being fully recovered and thinks that she is as recovered as she will be. She rated her recovery as being 75% as she no longer has a full range of movements and still has problems with carrying out certain movements and positions. Also Linda has been told by the physiotherapist 'that's as much as we can do now there's nothing else I can do'. Linda sees herself as having adapted to the injury and that all she can do is just carry on.

5.6 Rav: *tell me, why me?*

Rav was timid in appearance and nervous throughout the interview. He was the youngest participant and maybe that was why I felt maternal towards him as I tried to put him at his ease. I noticed how he kept his head still during the interview. During the interview I felt as if he had been looking to me for answers and I wondered if that was why he had responded to the invitation on the second mailing. This was the only interview with Rav as he failed to keep his other appointments.

Rav told me how his accident happened as the traffic came to a sudden standstill. He managed to stop in time but he could see the car behind him continue to move at about 25 or 30 mph and hit the back of his car. Rav said that he experienced pain at the back of his head at the time but that it calmed down. He was more concerned about his car, which ended up being written off, than he was about himself. The next

day he woke up to find his neck was really stiff, he could only just move it and it was painful. He asked his brother about it and he told him he had got whiplash and he needed to go and see the doctor. He said that he went to see his doctor that day because 'I had a bit of pain and it [his neck] was really stiff in the morning and I thought I'm a young lad and I don't know why this is happening'. The doctor advised him how to support his neck and he was given painkillers and an information sheet that contained neck exercises.

The injury affected Rav in several ways. The restriction in his neck movements combined with the pain, stopped him from participating in his hobby of five a side football and six months later he wanted to know why he still could not join in a game of five a side. He described himself as 'an active lad before the accident' who used to go to the gym three times a week. The injury also stopped him from sleeping properly as he could not sleep in his usual position of lying on his front. Sleeping in this position seemed to make the stiffness in his neck worse when he woke up. Also the pain would wake him up and stop him from getting comfortable and going back to sleep. He found this situation quite frustrating and described himself as getting angry in the mornings and he would ignore everyone in the household. At the time of the injury, Rav was unemployed so taking time off sick was not an issue. However, he was concerned about what he was able to do. This was because he did not know why he was still having problems with moving his neck; he was a young man and young people do not have problems like this and he was worried that it might stop him from getting a job. Rav has found his whiplash injury to be very painful; he described the strength of the pain as 8 and he has continued to experience the injury as painful. This

he finds somewhat perplexing, as none of the professionals he has seen have been able to tell him how long this will continue.

The physical nature of the injury has made driving more problematic for him due to the restrictions in neck movements. He is aware that he can not turn his head from side to side and on many occasions is unable to drive in a morning and has to wait until the afternoon or until he can turn his head more freely. Rav has become nervous in the car and finds that he is constantly looking in his mirror to check if anyone is too close behind him. If he thinks they are too close, he finds himself speeding up so the car will not be able to hit him.

Rav is claiming compensation for his injury as the accident was not his fault and the injury has continued to cause him problems. He put a claim in for compensation two weeks after the accident because the injury was still painful. The Consultant Rav saw as part of the medical legal process explained the problem as being one of tissue damage and that it can take four or five months to heal. As far as Rav was concerned, as it was six months later he should have been ok. Instead, he finds he is still having the same problems and once more he is wondering why.

Rav does not consider himself to be recovered from his injury. His reason for saying this is he still gets the pain at night and if he tries to sleep in his preferred position he wakes up with a stiff neck. He is concerned that as a young lad he should not be having problems like this.

5.7 Steph: *what if?*

Steph was very open and articulate, both verbally and emotionally as we began our first interview. This interview began with a lot of emotional overtones that reduced in intensity with her other interviews. I didn't experience the emotional intensity with her other interviews and I wondered about the unintended therapeutic benefits to the participant, of being able to explore their experience in the research setting.

Steph told me that her accident happened when she was a passenger on the coach that was taking her and her husband to the airport. As Steph started talking about her accident, her voice started to tremble as she recollected seeing a car heading towards them. The coach driver must have seen the car as he swerved, and then it happened:

There was a silence for what seemed like an eternity and the front of the coach window smashed. The driver seemed to be uninjured.

Steph then asked 'shall I tell you about my injuries first or the accident?' and before I could respond she started telling me about the accident. When Steph stopped, I asked her if she was ok and I asked her if she wanted to continue:

Yeah yeah I just [laughs] I had to type this back. Actually, a copy for [travel company] and my stomach, I could have been sick when I was talking about it to be honest. Right, do you want to know about our injuries now?

At the time of accident all she could think of was getting home back home and when she was seen by the ambulance crew it was decided that she did not require any medical attention even though her neck and hands hurt. Steph felt that they had all been lucky and that it could have been a lot worse. She just wanted to get home. Steph went to see her own doctor two days later, as by then she ached from top to bottom, as

if she had done a big workout at the gym. She had started getting headaches and was thinking constantly about the accident and what might have happened:

I feel glad to be alive to be honest. ...Yeah I just think my time wasn't up but it could very well have been. I'm just glad to be alive.

Her doctor examined her and said it was a whiplash injury. Steph wanted to know what she could do for it and wanted to go to the gym as this would give her a reason to feel like she did. She was told not to exercise but could do yoga or have a massage. She said she was told to do just what she thought and what she felt able to do. Steph was surprised that she was not given a follow-up appointment or any written information. Steph said 'I thought I knew about whiplash, but I think people who've never witnessed it, never had it before or anything, have no idea whatsoever'.

At first Steph took sick leave from work as she ached all the time. She also found herself unable to concentrate or settle to do anything as she kept thinking about the accident, or the aching would distract her. After a few days' sick leave she returned to work. She felt that work would take her mind off what had happened. Steph found the aching was more noticeable at work especially when she was sitting down at her desk. The aching made it difficult to concentrate on whatever task she was doing and she would find herself getting up and going for a walk around the department. Steph was able to vary the tasks she did at work and could take frequent breaks from working on the computer. She was able to continue as normal although she was not quite as efficient as usual. Steph's sleep was disrupted not only though the physical pain and discomfort, but also because she kept thinking about the accident and would wake up with nightmares. This was documented in her dairy which she read out to me:

*I don't think I slept for the first two and a half weeks properly.
I kept waking up, flashbacks, aching, but I'm alright now.*

Steph felt that she could probably have done more household tasks than she did but just did what she needed to do, such as making the bed and the cooking, as she felt too achy and just did not want to do any more.

Steph found the discomfort from her whiplash injury settled down within two to three weeks after the accident. She regarded the pain as an ache more than anything and compared her aching back, not her aching neck, to the back ache she experienced when heavily pregnant. 'You just don't know where to put yourself to get comfortable'. Steph rated her pain level as '6-7' and on occasion took paracetamol for the pain with no real effect on the aching but she thought it helped her headaches. Steph found the massage was more helpful in relieving some of her aching muscles but this was too costly to use all the time. 'I couldn't really afford to do that very often' and so she felt that she had to manage the aching as best she could and carry on in spite of it. Knowing what to do was very important for Steph and she used the internet to find out what she could do to help her manage how she was feeling and was disappointed to find most of the sites were related to claiming compensation.

As Steph does not drive there was no change in her driving and as a passenger in a car she felt just the same as she did before the accident and said 'it didn't happen in the car'. During the first interview, she was surprised to find that when she went on a coach trip she became quite anxious on the coach and immediately put her seat belt on. This was because she felt absolutely paranoid about accidents. She thought she would be ok but realised that she was still affected by her experience because of a

recent incident on a bus. ‘When he pipped his horn and braked, I really did have a fit. Well not a fit, but, er, my heart was in my mouth’. Steph felt that this was ‘for something and nothing’ that she would not have even noticed before the accident.

At the beginning, Steph was undecided on whether or not she was going to claim compensation for what she regarded as an unfortunate accident and in the end decided not to make a claim for compensation. Her family said that ‘she ought to do’ and she had been advised to do so legally but she felt that these things happen, it was an accident.

Steph considered herself to be recovered from her injury at the first interview as she was only experiencing occasional aches in her neck and she was able to do all that she could before the accident. A year later, Steph views everything as completely settled. The only difference that she is aware of is feeling more wary when travelling on a coach. Steph told me, ‘We are going back to the same place for our holiday next year, so I must be recovered’. I asked, ‘Are you going on the coach?’ and Steph replied ‘I don’t know about that. The taxi costs a little more than the coach but it is a lot quicker’.

5.8 Hazel: *There’s still hope*

I quickly established a rapport with Hazel, who at times struggled to put her experience into words to describe and make sense of how the injury affected her. In her final interview, Hazel expressed how she hoped her struggle to describe her experience would not be in vain and that the management of the injury would be better in the future.

Hazel told me that she was on holiday at the time of the accident which she saw as a minor accident. Her partner was driving the car and they had stopped at a roundabout when the car behind them drove into them. At the time she said that she had got 'a bit of a creaky neck' but thought nothing of it. She started to have pain in her neck a couple of days later and when it continued went to see her own doctor six days after the accident. She was advised to do neck exercises and to continue taking paracetamol to manage the pain. Hazel felt that there 'wasn't anything that could be done for it' as it was muscular and you just had to wait for it to settle. She felt that, generally, doctors do not have a lot of time and that, as a whiplash injury was not that serious, she felt she 'had to put up with it'. A year later Hazel feels disappointed and let down as she still does not know what to expect or how long her neck will continue to cause her pain and discomfort.

Hazel found the whiplash injury was quite disruptive for her, as it prevented her from sailing which was one of her usual recreational activities. She has a holiday home where they keep a boat. Hazel and her partner would spend most weekends there and they would go out sailing in all weather conditions. Hazel found that when she was on the boat, the rocking movements of the boat made her neck feel much worse. This led to her choosing to stay behind on dry land, while her partner and friends went out on the boat. A year later, Hazel only goes out on the boat when the weather is calm as she finds the jostling movements have continued to affect her neck. Hazel also found herself not being able to concentrate as well as usual and had become more forgetful, but puts this down to her age rather than associating it with the accident or the injury. The injury stopped her from sleeping due to the pain and discomfort from her neck and she found it difficult to get comfortable. She discovered certain positions like

lying on her front made it worse but this gradually settled down over a couple of months. Occasionally, Hazel will experience disturbed nights because of her neck.

Hazel found the whiplash injury caused her some problems at work because of the position she needed to take in order to carry out her work. Her work involves sitting at a machine to make objects. Hazel managed to continue working and limit the pain she was experiencing by getting up and moving about more. While the injury made it more difficult for her to do her usual work she was able to manage and not take any time off sick. This was important to her because of the financial implications of being off sick and she decided it would be best to 'just put up with it'. At the second interview, Hazel told me how an incident at work made her neck feel easier. Whilst she was telling me this Hazel became quite excited. She had been using a towel machine and the towel had got stuck. Hazel demonstrated the pulling movement whilst speaking and said:

I just like jerked my neck and thought, "My neck! Oh my goodness, my neck!" You know, my head went down to my chest and I heard it creak and I thought: "Oh, I've done something to my neck!" But then I don't know whether it's stretched or I did something to it. But I haven't, er, had any trouble really with it.

This description reminded me of a neck manipulation.

Hazel found the pain she was experiencing to be quite disruptive as it prevented her from doing the activities she enjoyed most of all. She described the pain as always being there but that it would change in severity and likened it to toothache in her neck and tried to show me where the pain was. She rated the pain at a constant level of '5' but it would go up to an '8'. Hazel took paracetamol to manage the pain but found they

were not really effective. She also used the neck exercises, which helped her movements but they did not make any difference to the pain she was experiencing at the time. Hazel has continued to manage her pain by 'putting up with it' and only takes painkillers when the pain becomes too much for her.

Hazel described herself as being an observant driver but said she had become 'jittery' in the car. The accident had made her become more watchful of cars coming down the road and she would think to herself 'if it just goes over the line in the road...'. The jitteriness in the car settled down and at the final interview Hazel felt her driving behaviour had not changed in any way. She drove in the same way as she did before the accident.

Hazel decided that she would not be making a claim for compensation for her injury. When I asked her the reason for that she was not able to say why she made that decision. All she would say is 'I just haven't'.

A year after the whiplash injury, Hazel does not feel that she has recovered from it. Her reason for saying this is because she is still experiencing pain in her neck and she still has to be careful about what kind of movements she makes. Hazel showed me how she tried to 'not jerk her head' and hold it still as that made her neck 'creak'. Hazel only goes out on the boat when the water is calm otherwise she stays behind as the effect of the choppy water makes her neck feel worse.

In this presentation I have looked at each person individually but it is clear that there are some key themes that cut across their experiences.

Chapter Six: Patient Interviews: thematic analysis

This chapter presents the themes that have been derived from the template analysis that was carried out on the patients' interviews. All patient participants have contributed to all the themes. Having discussed the development of the template earlier and for the sake of brevity, I refer the reader back to chapter four for a detailed approach on how the themes were derived. Suffice it to say that the themes were arrived at through a continual process of reading the texts and modification of the codes. The codes are also represented hierarchically so that the highest level codes represent broad themes in the data whilst lower level codes represent more narrowly focused themes within the data (see appendix 15 and tables 3 and 4). I have chosen to be selective in discussing the codes within the template, and will be focusing on those aspects of the template which I think are more interesting and add to something to the understanding of whiplash injury. This is because some of the codes, such as identifying the problem, pain and stiffness just tell us what is already known about whiplash injury. This means that this chapter will be structured to follow the same order as the overarching themes appear on the final template on page 126 but will not include all the lower level themes. In the transcriptions I used the symbol [p] to indicate where a pause occurred and this can be seen in some of the quotations I have used.

Five overarching themes have been identified from the coding template. These are: healthcare experience, embodiment, making sense, patient expert and 'Whiplash: a minor injury?' From the five identified overarching themes, the theme on healthcare experience was an a-priori theme. The second order theme of 'pain', which is integrated into 'embodiment', was also an a-priori theme. The theme 'Whiplash: a

minor injury?’ takes its name from the status given to whiplash injury in accordance with the prevailing view of the biomedical world. This theme appeared to differ from the other themes in that, like a thread, its presence was felt in all the themes and in many ways has proved a difficult theme to place. I think this is due to the fact that whilst it exerts an influence on the other themes it was not necessarily an integrating theme as such. In the end, I decided to end the thematic presentation of the material from the participants with the theme ‘Whiplash: a minor injury?’, as this appears to be a pivotal theme between the accounts of patient and doctor participants.

6.1 The Healthcare Experience

This theme looks at the experience of healthcare from the perspective of those who have had a whiplash injury. This important, but often neglected, view can be a valuable resource for healthcare professionals for two reasons. First, it increases understanding and awareness of how specific conditions such as whiplash injury can impact on lifestyle[s]. Secondly, the patient perspective can assist the healthcare professional in the process of evaluating the effectiveness of interventions aimed at the treatment and management of that condition (Anderson and Bury, 1988; Morse, 2002). The focus of the healthcare experience in this study is on the participants’ account of what took place in the consultation[s] with the doctor and how the participant felt about their experience. This theme looks at diagnosis of the condition, treatment and management of the injury, type of information given and how the participant felt about their experience of healthcare.

From the case studies, in the preceding chapter, we saw that the participants sought medical help because the disruption and pain they experienced from their injury was

more than a mere irritation. The extent of the disruption experienced from their whiplash injury led the participants to believe that their injury might be more serious than they had first thought. Medical assistance was sought with the expectation that the doctor would be able to diagnose and give or arrange treatment for their condition.

6.1.1 Treatment

Whilst the identification of a whiplash injury proved to be straightforward, the treatment or management of the whiplash injury to the satisfaction of the participant was a different matter. The treatment received by the participants consisted of being advised to take a painkiller, such as paracetamol, for the pain, and some were advised to do neck exercises. The treatment received by the participants in this study led them to feel that the effect of their whiplash injury was not taken seriously or that little could be done to treat the problem. The whiplash injury was no different to a small but painful cut which you are expected to put up with:

*It was like it was somat and nothing. Because it's been giving me a lot of pain it was treated, I think, like it was somat and nowt like an everyday occurrence and I just have to go away and get on with it.
(Linda).*

Bill went to the Accident and Emergency department after his accident, where he felt that his whiplash injury had not been taken seriously:

*Frances: So it was the casualty you went to see and it was the casualty doctor that you saw and he just said take paracetamol?
Bill: Yeah basically [Wendy laughing]
Frances: [to Wendy] You're laughing about that? [Bill joins in laughing]
Wendy: They didn't even x-ray you did they?
Bill: No. They didn't check me out or anything.
Frances: They didn't check you out, and didn't x-ray you, just based on what you told them?*

Bill: Yeah, he just felt round my neck and said yeah, it's whiplash, take paracetamol and you'll be alright.

When Bill saw his own doctor, he felt that his whiplash injury had been taken more seriously than it was at the hospital. Bill highlighted the fact that by the time he saw his own doctor his posture had changed. The change in posture had the effect of making the whiplash injury more visible and this might be one reason why Bill felt that his own doctor had taken his condition more seriously:

Bill: Well, yeah, but I was walking bent over double.

Wendy: Yeah he was walking bent over double. But I think that the doctor was pretty good.

Bill: Yeah. But I kept going back.

Wendy: And you got appointments when you needed them as well.

The appointments were used by Bill as a way of demonstrating to me that his own doctor had taken his condition more seriously.

Margaret thought that there had been no change in treatment or the way patients were advised to manage their whiplash injury:

Margaret: The doctor said he would give me some anti inflammatories and some painkillers [p] and hopefully that would be enough to calm it down relatively quickly.

Frances: Right. So besides the exercise, were you given any other advice about managing?

Margaret: No.

Frances: No?

Margaret: No and I can't say that that was because he had looked at my records and said: "Oh she's been here before" because I never got much advice before the previous time.

NHS treatment

Apart from advising or prescribing treatment for the pain, physiotherapy was another treatment that was mentioned by the doctor as a treatment that might be of benefit in

treating a whiplash injury. Unsurprisingly, none of the participants in this study were referred to a physiotherapist for treatment of their whiplash injury. The difficulty faced by the participants in being referred to a physiotherapist for treatment appeared to have as much to do with the categorisation of a whiplash injury as a minor injury, rather than the actual problems with the movements that were being experienced by the participant. There were two obstacles that participants had to overcome in accessing a physical treatment for their whiplash injury. The first was being able to obtain a referral for physiotherapy on the NHS for a condition that is seen as minor, and the second was the long waiting list for conditions that are seen as being non urgent:

He didn't recommend. Well he said try, no he didn't actually recommend that I go to a physio. Just to try this, these exercises, because it'll make it a lot easier for a physio' because you've done half of the physio' already for them. (Martin).

James also found that he himself had to decide on whether or not to have physiotherapy as a treatment, as opposed to the doctor making the decision. James was told by his doctor that he could have some physiotherapy if James thought that he needed it, but there was a waiting list. James felt that he did need physiotherapy and that he needed it sooner rather than later. Having to decide whether or not to have treatment could be seen as the doctor's attempt to involve James in the decision making process. This might be an important aspect when resources are limited and the patient is required to fund their own treatment.

It can be seen that the option of having physical treatment for their whiplash injury from a physiotherapist on the NHS was not readily available for the participants in this study. Instead, the provision of physical treatment from a physiotherapist

depended entirely on the participants' ability to pay for their own treatment unless they joined the NHS waiting list.

Bill went for private physiotherapy treatment and justified this expense:

Bill: And I were going there three times a week [Frances right] for about two month.

Frances: That'd be quite expensive then.

Bill: Yes. Cost me about six hundred quid, didn't it?

Wendy: Yeah. But then you're self employed and you needed to get back to work.

Linda, who was unable to pay for her own treatment by the physiotherapist, was fortunate in as much as her solicitor had been able to arrange for her to have physiotherapy as part of Linda's claim for compensation.

Two of the participants found that the emotional distress they experienced with their whiplash injury was also recognised by their doctor:

*I was getting headaches and flashbacks and I just felt really, really down on the Monday. And she [the doctor] actually gave me some diazepam to try and calm me down and to help me sleep.
(Steph).*

Bill describes his emotional distress as frustration because it was taking longer than a week to recover from his whiplash injury.

Bill: Oh I was just thinking a week, you know, a week and I'll be alright.

Wendy: But you got depressed over the period you [inaudible].

Bill: I did, yeah

Frances: Right

Wendy: Very depressed

Bill: Well it were the frustration of it

Wendy: And [p] I think, well, the doctor was aware of that. He was very good, he talked to you didn't he?

Other treatment providers

The lack of treatment options available from the NHS for treating whiplash injury, led some of the participants to look at seeking help in managing and treating their whiplash injury outside of the NHS.

Martin went to see a chiropractor for treatment. Whenever Martin continued to experience difficulties from his whiplash injury, he chose to see the chiropractor instead of his own doctor. This was because he felt that the chiropractor could put the problem right whereas his GP couldn't:

I'm gonna have to go back to him again because, again, I don't know if it's my job with me having to bend in certain positions, he [the chiropractor] just puts it right. Well the GP [p] all he can do is generalise and he's gonna refer me to somebody like a chiro' or a physio' or someone like that.

Steph's doctor suggested a massage might be a helpful treatment:

I actually found the massage did help a little bit, short term. But money wise, I couldn't afford to have that done every week.

Margaret had considered going to see an osteopath as she had found this helpful with a previous injury. But on this occasion decided it was too expensive for her at this time in her life:

I was considering going back to my osteopath. I thought, "mm...it's a case of going private" and I couldn't afford it. [Frances right] It can be very expensive. My last osteopath was £25.

6.1.2 Information on whiplash injury

All the participants felt that the information they were given about their whiplash injury by the doctor was limited and that more information could have been given to them. The participants wanted to know what to expect and to have an idea of how long it would take for the whiplash injury to settle down:

*Well I think I could have been given more information really. I mean in [p] I do [p] I thought I knew a bit about whiplash. But I think people who've never witnessed it, never had it before or anything, have no idea whatsoever.
(Steph).*

*...a bit disappointed really [p] because [p] the whole ...when it comes down to the whole thing, it's unknown, innit? You don't know what sort of pain you're going to go through. You don't know what to do. There's nothing there for you. I mean, I still don't know how long it's going to take.
(Hazel).*

Hazel took the lack of treatment and information to mean nothing could be done to treat a whiplash injury. This stopped her going back to see the doctor as she thought she had to put up with the problems that were caused by the injury:

...Go away and try it and if it's not right, come back. If he had said there's something else we could do for you, I would have probably gone back. But because he just said to me, er, 'go do the exercises and take the tablets', I feel like, well, what's the point in going back? [Frances. right yeah] I think if there'd been a leaflet maybe. If they'd just said if it continues you could go to whatever [other health professional] to have it seen to, I might have gone [back to the doctor] and if there were a time span of how long it's going to last.

6.1.3 Participant evaluation of healthcare

The trivial manner in the way the whiplash injury was managed manifested itself in a general dissatisfaction with various aspects of the healthcare experience. The lack of

appropriate treatment[s] for whiplash injury on the NHS left Margaret feeling disappointed with what could be provided by the doctor to treat her whiplash injury.

She also felt the treatment was totally inadequate:

I think it's extremely inadequate the help and advice you do get. It's too long to see a physiotherapist and you're not given, up until that point, any advice on self management [Frances. right] which I think is quite poor. You're just given drugs.

This situation led Margaret to lack confidence in what the doctor could do to treat her whiplash injury: *'I haven't got much faith in what the doctor can offer me'*.

Margaret compared this experience of receiving healthcare, with her previous experiences of healthcare for a whiplash injury and felt that the care offered for a whiplash injury had not changed during that time:

I don't think it's improved. I don't think it's moved on. [p] I really don't think that you get any better assistance now than you did do then.

At the hospital, the lack of time given to Bill by the doctor led him to feel dissatisfied with his consultation:

I wasn't right impressed. Well, I was literally in and out in 5 minutes. Waited 3 hours and then [Frances. right] 5 minutes later I were back out.

The lack of time given by the hospital doctor to Bill, contrasted quite sharply with the time given to Bill by his own doctor who saw him on several occasions.

Bill's partner Wendy goes on to describe the difference between the two:

Yeah at least he showed some concern and it wasn't just like at the hospital: 'It's just whiplash, go away take paracetamol'.

The lack of information and treatment about what a whiplash injury entailed, together with the lack of follow up care, led Hazel to feel unsupported and alone in the management of her whiplash injury:

I think that they could do more [p] a bit more supportive of [p] yeah I think the doctors could be...I think the doctors could explain it better. And maybe sort of like say, well come back in six weeks, or come back in eight weeks and we'll see how you're going on [p] and then maybe see what we can do for you. Because then you'd know what to do, what not to do, where to go, or things like that.

Frances: So it's something about the not knowing?

Hazel: Yes it is. It's not knowing. Because you don't know what to do, do you? I mean, if you have an accident [p] there's just, unless you go to hospital, there's no one to do, because the doctor just said oh yes you've got whiplash and [p] take painkillers. I mean, how long do you have to take painkillers for? I mean it's been a year now hasn't it. [p] So do you still [p] go on taking them for ever and ever? And you don't know, do you?

Martin's evaluation of his healthcare experience was different from the other participants. He was able to pay for his treatment and was satisfied that the doctor had been able to do all that he could:

Martin: At the end of the day he's only a general practitioner. He doesn't know everything about everything, does he? As a general practice he gave me as much information as he could. He were only a young doctor. The healthcare side has been alright because, I mean, I've had to pay. So it has been alright because it's been private care more than NHS care. NHS care I don't know because I never used it. [Martin starts laughing]

Frances: Never used it?

Martin: I mean, I never went to hospital or owt like that. Apart from when they had to check me out as part of my claim. Otherwise, I haven't used it.

6.2 Embodiment

This theme demonstrates how the changes that are first felt in the body are then experienced within the psychosocial realm between self and others as taken for

granted acts or projects are suddenly brought into question until adaptations or accommodations to the changing sensations brought about by whiplash injury take place. With this in mind, I will now go on to present the rest of the material in this theme.

6.2.1 Disrupted Body Movement

A whiplash injury produces a felt bodily distortion that may or may not be accompanied by pain. The distortion is demonstrated through changes in the way the body is able to move. The distortion felt in the body, draws our attention to the everyday taken for granted body movements. Like the child who is learning to walk and run, we once more become aware of our moment to moment bodily sensations and movements. All the participants talk of disruption to the way they move, and note that they have to think about actions they have carried out before without thinking: the acts of moving, turning, lifting and so on. Everyday movements that we take for granted until once again the body accommodates the injury:

*I think it was about two days later when trying to reverse the car down and I sort of went to turn and thought, 'ooh!' and it feels as though you have to lift the whole of your body to turn round there and you have trouble rotating your head and it's quite cumbersome, actually, you feel like you're a bit heavy and useless.
(Margaret).*

Margaret felt that the changes in her body made it seem heavier than it actually was and she had to think about the movements she was doing. The conscious awareness of thinking about what she was doing instead of just doing it also contributed towards her feeling of being useless. No longer did the movement or action flow. It had become stilted and obstructed.

Bill's partner, who was present during the interview, could see the changes in Bill's posture:

You didn't know. I mean. you seemed to get worse as that first week progressed, you know, the back problems, the shoulder all came out and the neck, it was like you were hunched over.

Martin found that he had to change the way he did things at work to accommodate his whiplash injury:

I'm still doing the job but I'm having to do it differently. I could do my job without any problems. I could lift things without any problems, er, now I just have to be more cautious than anything else.

The whiplash injury has made Martin more cautious at work because he is fearful of making his problem worse, and financially he could not afford to take time off work.

He is self employed:

'I can't afford no time off work to compensate. I daren't do it, [physical work] because I don't want to put it [my back] out'.

There appears to be an elusive quality about the hidden unspoken nature of the condition that lies deep within the body, away from prying eyes of x-rays and body scans. Unlike bones that have a concrete mass that can be seen by an x-ray, body movements and pain are concerned with receptors that are located within the nervous system. The subtlety of the continued disruption and change to the way the body moves, can, in some cases, lead to new, but not necessarily better, postural stances and movements as the body accommodates and adapts to the new situation.

James found that he no longer had the same range of movement with his head which only became noticeable when he was driving: *' I can't turn my head as far as I used to when looking to see what's behind'.*

Margaret described how she had been totally unaware of the changes that had taken place with her posture as her body had accommodated and adapted to the changes brought about by the whiplash injury. This was when Margaret had her first whiplash injury:

Yeah, you fold into yourself [she demonstrates physically]. As a result of which, the muscles across the front shorten. It took about a year for it to happen. Somebody said to me, I have a friend who used to go to ballet, and she said, 'For goodness sake, stand up straight!' and I couldn't. [Frances. right] And she said, 'Come here, have you noticed your posture?' and I was extremely...I started to notice myself, but it took somebody else to point it out. I was extremely round shouldered and I'd always had very good posture before that. So it took about two years for the Alexander therapist to actually gradually stretch the muscles back.

6.2.2 Experience of Pain

From the interviews it would appear that the nature of the pain experienced with a whiplash injury differs from other injuries in that the pain is often absent at the outset but begins to make itself felt over the first few days. The pain from a whiplash injury is interesting in that it seems to increase in severity until it reaches a plateau and then becomes constant, neither getting worse nor getting better, unless the pain is exacerbated by movement. This appears to create an enduring quality about the pain experienced with a whiplash injury that can persist for months and possibly years after the injury took place. Many of the participants continued to experience pain at the final interview a year later. The pain that is often rated as moderate to severe by the participants led them to question whether in fact the injury was more serious than they had been led to believe:

...and it was two days later, I was in so much pain that I booked an appointment with my chiropractor to do something.

*Sometimes it can be really painful and go beyond 10. Yes, it can be really really painful. When it first happened, [p], er, when it all kicked in. I was in that much pain, it nearly drove me to tears and I'm not a crying type of person but I was in that much pain it really was bad.
(Martin).*

Bill found himself in so much pain that he booked an appointment with a private physiotherapist after his hospital visit and before he saw his GP:

I'd already booked into a private physio by then because I couldn't stand the agony of it.

The pain from whiplash injury is often felt hours, or even days, later:

*It was, it was just the pain really. It didn't, it didn't come on straight away. It was a couple of days after, that I started getting the pain in my neck. But, I mean, the pain is always, I can't say that it goes away. The pain is, it's always at the back of your neck [points to where it is].
(Hazel).*

Linda also found that certain movements would increase the pain she experienced:

*If [p] I move awkwardly and jar anything, my neck, then it would be, just for a minute or two, an eight and then the rest of the time I'd just be a four, five.
(Linda).*

Six months after his accident, Rav was still experiencing pain and discomfort from his injury and this led to a failed expectation about recovery:

*Rav: At the moment I'd say it's about seven but when I have the cocodamol it does tend to settle. But I'm still getting the pain.
Frances: So it's not really settling, is that what you're saying? And how do you feel about that?
Rav: I thought it would have worked but all I can do is just take the medication, isn't it, and wait for it to settle.*

The absence of pain or the strength of the pain that is experienced was one of the indicators that were linked to the participant's notion of being recovered from the

whiplash injury. Steph considered herself recovered because the pain had more or less settled and the whiplash injury had stopped getting in the way of her normal activities:

Frances: Would you describe yourself as recovered from your injuries?

Steph: Yeah [p] yeah.

Frances: And what makes you say that?

Steph: Because I don't ache. I'm saying I don't ache totally. I still do have pains in my neck occasionally but I don't ache like I did.

Martin could not see himself ever being pain free again:

Yeah. It's like I say, I'm in pain constantly, constantly, and, if it's right what the specialist said, it's gonna be 18 months, it's gonna be 2007 by the time [p] I'm anywhere near right. So [p] I don't know [Martin laughs]. I don't feel as if I'm gonna be right or if I'm ever going to be right.

This experience also meant that Martin could not imagine that he would ever be the same again.

Management of Pain

A variety of medications were used to treat the pain, which included prescription and non prescription painkillers. The medications used had varying degrees of success at reducing the pain but did not appear to take the pain away. It is interesting that the participants appeared reluctant to take medication to manage the pain from their whiplash injury. This could be due to several reasons that could be related to the labelling of a whiplash injury as a minor condition. The first is that a whiplash injury is so trivial that the pain and discomfort should be tolerable:

*Like I say I'm not a medicine man. I don't like going to the doctors, the dentist or hospitals. If I'm in pain, I try and grin and bear it.
(Martin).*

Linda: I'm not taking owt now. I don't like taking tablets so I've stopped taking anything.

Frances: You're just, what, putting up with it? Is that what you're saying.
Linda: Yeah, yeah.

The second is a reluctance to take substances which are known to have side effects that can affect the body or can become addictive. The taking of medication to relieve their pain was often seen as being more detrimental than putting up with the pain and discomfort from a minor condition. Martin reported how his doctor told him that continually using the pain killers to manage his pain could lead to him becoming addicted to them:

A 1000mg a day. He just said, take them as and when you need to, not all the time, if you can, because they are addictive or something.

Hazel: You tend not to take the tablets unless you really have to and then that does help it. But I try not to really.
Frances: You say you don't like taking the pain killers. Is there any particular reason for that?
Hazel: [p] not really [p] paracetamols aren't very good for you. I don't think any tablets are good for you really. So I don't really want to [p] if it gets bad I take them and if not I just put up with it.

Other strategies used by the participants in managing their pain, involved the use of alternate or complementary therapies:

'So I booked into the chiropractor, which I know quite well, and he took the pain away completely for four weeks.'
(Martin).

The use of heat and essential oils such as lavender were also used as an alternative to medication.

The poor management of the pain that is described as severe by the participants in the early days following the injury may well be one reason why the pain experienced

from a whiplash injury enters a chronic phase. Pain is also a reason why the participants restricted their bodily movements and the actions they carried out in an attempt to manage their pain. Also the pain that is experienced from whiplash injury appears to overlay itself on to the disruption that is experienced with everyday movements. Together, the experience of pain and the disruption to movement create a different bodily experience which alters the familiar landscape of the body.

6.2.3 Disruption to Lifestyle

The injury seems to permeate every aspect of life by affecting the participants' ability to carry out their normal range of activities both at home and at work. Basic activities that we do without thinking, such as getting dressed, can become problematic. This increased their dependence on others to do work for them. This can actually mean lifestyle changes for people, which, in some cases, could be potentially isolating socially, or mean changing or limiting the kind of work that they do.

Bill described it as 'life being brought to a standstill', as everything he was doing stopped or went on hold through his whiplash injury:

Bill: I was at halfway through building my garage [p] which that [p] stopped. About middle of summer before we actually got that built.

Frances: Right, so it really was [Wendy talks over]

Wendy: Big upside down.

Bill: Yeah, yeah. Well, er, one of the main disappointments is like lad does grass track racing. [Frances right] And we all did, you know, 'cause it was something that, you know, we'd got the car and, er, it was his car and his hobby. [Frances right] But we all had to go so we all joined in. I raced, she raced. I've not been able to race since.

Hazel found that she had to stay behind whilst her family carried on without her:

'It hasn't stopped us from doing anything. It's just that they've got to go and do it on their own and I don't go with them'.

A year later, Hazel found that at times she would stay behind whilst her family went out on the boat:

Hazel: Yes but I have yeah. I'm just, as I say, I'm just careful what I do now. I don't [p] I don't go on the boat if it's rough. I stay [p] on shore. I'm just careful what I do now.

Frances: So does being on the boat when it's rough make it worse ?

Hazel: It does yeah.

Frances: How does that do it then?

Hazel: It just bounces you up and down, and sort of, your neck is, you know? Because your body's jerking up and down it does affect your neck and it is quite painful.

The way in which the whiplash injury isolated Martin from his wife becomes evident when they are trying to sleep at night. Martin found that his whiplash injury disrupted his sleep and he had difficulties with his usual sleeping pattern. This aspect proved quite puzzling for him, he couldn't understand why he should find it difficult to sleep:

No, she prefers it sometimes. As I say, she can get some sleep, [Martin laughs] because, I mean, when it gets to 2 or 3 O'clock in the morning, she's had enough. All she wants to do is sleep. She'll say go on, get out, go and sleep downstairs. It's quite a regular thing at the moment that I'm having to sleep on the floor because of my backache. It does, it feels a hell of a lot better after [p] than when I'm sleeping in the bed. I can't understand that, because, like I said, I've got an orthopaedic bed, it's strange but the floor does, it's nice and hard.

Others are determined that nothing should change because of the injury and then, as they reflect on their experience, realise it has changed what they do or how they are:

'Yeah I won't let it stop me from doing sommat. It's just, it's in charge of me' (Linda). It is interesting that this comment by Linda reveals the nature of the injury as

being paradoxical or contradictory. Linda also finds it difficult to admit or believe that having the injury has changed what she can do:

I think I adapt to it [Frances: right] rather than, say, 'oh it's bothering me, it's bothering me', because it's there, it's always gonna be there. I just like get on with it. You use it how you should or rather, I use it how I can instead of how I should, you know what I mean?

Frances: Anything to make life easier for yourself. I know you said you turn your whole body.

Linda: I know this is a bit daft really. But if, on a Friday night, sometimes I go to the pub and watch rugby on television, I always like to sit at a place where I can see straight forward on the screen rather than just turn my head. I can't sit for an hour and a half with my head turned, so I try to sit facing it. And if I don't get a seat facing it then I have to sit with my whole body facing it like that, and I turn around in my seat and face it like that [physically demonstrates]. I can't just sit like that. Well, I can't do it.

Margaret found that her first whiplash injury was more disruptive than her current injury as her circumstances were totally different then:

I think the first injury was the worst I had because I was having treatment for about two to two and a half years and it did have quite a serious impact. I had a young child at the time and I couldn't lift him and, you know, I was in quite a difficult position and we were decorating a new house that we'd bought and I couldn't really help as much as we planned. I just couldn't manage. I was the main bread winner at the time and we couldn't afford for me to actually be off work so it made life quite difficult.

With her most recent whiplash injury, Margaret was supported at work by her colleagues and at home by her partner and son:

One of the other girls, anything I was supposed to do, she actually did it for me. She did my duties as well as hers, because they were that keen to have me at work. [Frances right] And I was allowed to have a lie down whenever I felt the need. So they really made it easy.

Martin relied on his business partner to carry out the work:

I just felt sorry for my partner more than anything, just because, physically, he had to do everything. Yes, he was more or less running the company himself apart from the paperwork because I was doing it.

The disruption experienced by Steph as result of her whiplash injury when she was at home was minimal and the affect only lasted for a few days:

I probably could have done most things but I, er, it's just, you know, when you ache and you don't want to do it. But I think I could probably have done things, if I had wanted to do them. It didn't stop me cooking or making a bed. Doing the everyday things, but anything extra I just didn't want to.

However, when Steph was at work she was more aware of the disruption created by the whiplash injury:

I couldn't sit at my desk for quite long times because obviously the job that I do, well, I have to sit at my desk for quite a long time. So I have to keep shuffling about or getting up and having a walk.

A less obvious but equally disruptive aspect of the experience of having a whiplash injury becomes evident with everyday travelling. Surprisingly, the anxiety evoked by the whiplash injury appeared to be enduring in nature. The participants found that they would become anxious in the car, or when travelling, and that this became a consistent feature.

Linda was surprised to find that a year later she continued to experience anxiety when driving:

I'm glad it's over, but having said that, I had to brake quickly tonight and I panicked, I mean, I cringed like that [physically demonstrates] because I was waiting for somebody to go into back of me. So that part of the accident hasn't gone away from me yet. Not at all. I don't like anybody being behind me and if I have to stop [p], even not quickly, if I have to pull up slow, like, I do it really steady and make sure I'm braking all time

so that they can see me lights to make sure they're gonna stop, so I'm always aware.

When asked what that was about Linda responded:

Linda: That's from him coming smashing into back of me. I've been like that from day 1. If you listen to interview on day 1 that's what I were like, ha ha. I do, I don't like anybody being behind me and it's still the same.

Frances: Still the same?

Linda: Yeah [p] I thought that would have gone by now, but it hasn't done.

For Bill the fear of 'it' happening again is ever present:

Bill: But often if I'm waiting at a junction, my eyes is on mirror [Frances right] and anything that's coming towards me. I'm just, you know, consciously thinking, 'Are they going to slow down enough? Are they going to stop?' [Inward breath].

Wendy: It's like a paranoia when you get to the junctions, because your eyes are going like this to the mirror, even if I'm driving. [Bill & Wendy laugh] (Bill and Wendy)

6.2.4 Changing sense of self

Over time the whiplash injury appears to influence and change the way in which participants begin to see themselves. This process appears to take place as the pain and disruption caused by the whiplash injury in the early days following the injury continues to be experienced in the ensuing weeks and months that follow on from the injury. The effect on the self concept appears to be linked to the longer term outcome of the injury. If the difficulties brought on by the whiplash injury settle fairly quickly, the threat to the self concept is transient. However, the longer term effects from the whiplash injury appear to have a more enduring affect on the self concept as the individual changes and adapts to how they are now. It is interesting that the development of a sense of self, together with the development of the skills, such as

learning to walk and run, which take place in the early years of life are brought to the fore through a whiplash injury. The notion of what recovery means for the participant, and whether they consider their self to be recovered, also appears to be relevant in terms of the self concept, as it brings into conscious awareness the self and the everyday lived experience of work and play and what steps, if any, are needed to manage their situation.

When James first experienced not being able to move his neck, he thought that he might become a different person:

Well your spine, it's the centre of you. That's where you are and what happens if this continues. [As if to emphasise what he was saying James demonstrated the physical movements of his neck.] You can't move your neck properly. [He suddenly became aware of what he was doing]

In the early days and months after having a whiplash injury, Linda felt as if she was a fraud because the injury could not be seen and only she could feel the effects of it.

The lack of a visible injury led her to question the legitimacy of her experience:

It would be better if you could see evidence of your injury, say have an x-ray or something, without all this waiting and all this palaver and have an x-ray and say that's what it's done. It's like, get it sorted out.

Linda stopped feeling a fraud when she was seen and treated by the physiotherapist several months after the onset of the whiplash injury.

Dependency from chronic illness might make people feel more childlike but here, it is the opposite. The change in self image evoked images of being much older.

Martin became aware that he was no longer the boy racer and had become more like an old man when driving:

Martin: Yeah, oh I'm usually quite, well, I class myself as a reasonably good driver. Anyway, I've been driving that long sometimes when, before the accident, I have a little bit of a hair raising moment someone's cut me up and things like that I go up to their tail end. But now I don't, I back right off now.

Frances: Back off?

Martin: Yeah, I mean, I don't mind doing the old man at 20mph.

When I asked Martin why he saw himself as an old man he responded with:

Well that's how, when I used to be the boy racer, I was stuck behind the old man driving at 22mph or the old lady. [Martin laughing Frances joins in laughter] In a big volvo or a big jag or somat like that and they went at 22mph.

Martin also used the image of the older man to describe how he felt when he becomes aware of his physical body through the effect of his whiplash injury:

Martin: Yeah it's starting to twinge in the base of my back. [Frances. right] When I get up I'll go, 'Oh, Christ!' [Martin laughs] as you do... It does, it puts about 10 years on you.

Frances: Does it? You feel like an old man?

Martin: No. It does really, it puts 10 years on you

Frances: Does it?

Martin: Older than yourself and I don't know why. I feel like getting hold of a zimmer frame [Martin laughs].

Martin attempts to banish the feeling of being an old man and not being able to do things by telling himself to stop behaving like a baby:

Frances: That mustn't sit very easily, if you feel 10 years older, having to get a zimmer frame.

Martin: Erm I don't know, after a while 25 seconds or so you think, 'Oh sod it! Get on with it. Stop being a baby, er, you can do it.'

Margaret also describes her physical body as being old:

I am only forty and I tend to feel at times I'm a lot older than that compared to other friends at my age [Frances mm] who are very active, very full of beans and I'm sort of quite old really in comparison. In the exercise I can do and the limitations that I have.

6. 3 Making sense of their injury

When the trauma first took place, the participants felt they had not been injured and were not prepared for what they began to experience. At the time of the accident the participants' view of not really being injured accorded with the prevailing view that it was 'something and nothing'. The extent of the pain, stiffness and difficulty with movements took the participants completely by surprise and made them question their initial feeling about not being injured. It was at this time that the participants' actual experience of their injury began to differ with their earlier interpretation that they were all right and they sought medical help:

Frances: So then, how do you think you should have been treated? Have you got any ideas?

Linda: I don't know, just to see if there were any damage or, erm, I don't know.

Frances: Did you feel there might be more damage then when you went to see them?

Linda: [p] I don't know, just that, because I've had trouble with the bottom of my back, as well as my neck. I just wondered if there was more damage done than they thought there was.

When James's neck started to cause him problems, he thought: '*Neck: it's a spinal injury. It could be really serious. It could be long term*'. James found that his whiplash injury settled down and everything was alright.

Rav also struggled to make sense of what was happening to him: '*I'm a young lad and I don't know why this is happening because I've never experienced it before*'.

The effect of not being able to carry out his usual activities was made more difficult as he was only eighteen and eighteen year olds don't have problems with carrying out activities:

Well, I used to go to the gym and I don't go now. I used to play five a side and that. When I have a stiff neck in the morning, I can't really drive in the morning and have to wait until about after midday about 2 or 3pm and then I can start.

Steph wanted to be able to link her experience directly to a physical cause such as overdoing it at the gym, as she thought it would justify and legitimate her experience. It would have been easier to accept how she felt if she could have blamed it on something:

I felt like if I had a good workout or something it might take the pain away or at least you could feel, justified with having pain.

The extent of the difficulties that were experienced by the participants led to a sense of fear and uncertainty of the outcome of the injury and what the future might hold. This state also brought into question the minor status of the injury; it did not really make sense in light of their experience. In order to increase their understanding and make sense of their experience the participants utilised different sources of information to assist in that process. Often participants would revisit the memory of the accident and use the information given to them by their doctor or therapist to aid their understanding of what they were experiencing. One conclusion was that their injuries could have been a lot worse. They had got off lightly and they made comparisons against other types of injuries:

Martin: Lucky for me, er, I think it were more luck than management that I had put my seat belt on 'cause I don't normally. [Martin Laughs]

Frances: Don't normally?

Martin: Or I could have gone through windscreen.

By making a comparison with the worst possible scenario of having a fatal injury in a car accident, Margaret was able to consider herself to be fortunate to have had a whiplash injury:

*Ok, somebody hit me in the car. I've had an injury, but I'm lucky to be alive. You know, I could have had really serious injuries. I could have been cut to ribbons. So you have to consider yourself as fortunate to have got away with what you've got.
(Margaret).*

Bill came to the conclusion that although his situation could have been a lot worse he had in some way contributed to his injury being problematic: 'It all happened so quick. But it was the bracing myself and holding myself stiff that did myself more injuries'.

Although Bill felt he had inadvertently contributed to the fact that his whiplash injury was more problematic than it should have been, both he and his partner concluded it wasn't Bill's fault and he could not be held responsible for his situation:

Wendy: If you hadn't seen it coming you would have been more relaxed.

Bill: Yeah.

Wendy: The seatbelt. Yeah, you would have got whiplash, but the seatbelt would have taken the pressure.

Bill: mm mm.

Wendy: But the fact that you saw it coming. That's what the doctor said, didn't he? If you hadn't have been braced, your body would have gone in a natural rhythm back and you would have got the whiplash. But because he was braced as well...[Bill talking over]

Bill: That's what did my shoulders in.

Wendy: It's not, I mean, you wouldn't think like just having a tap in the car, but then it's like with the car...It actually wrote the car off and it was an Izuzu Trooper. So it's a big thing. [Frances: right] It hit him with that much force that it twisted the chassis. [p] So, I mean, when he drew up here on the driveway I thought, 'Oh well, it's only like the back bit'. But when the car was examined it had actually twisted the chassis.

I mean, it was a truck that hit him so, you can understand how, although it doesn't look massively bad does it?
Bill: No.

Bill's partner demonstrated how appearances can be deceptive. There is more to this than meets the eye. She thought the truck didn't look too badly damaged, although it was a write off. This is similar to the way that a whiplash injury gives the appearance of being something and nothing.

Linda also considered that she might be responsible in some way for the restrictions she experienced with some of her movements and postures. This was in spite of the fact that she had not been given information about exercising at the outset:

Linda: He did a lot of work [p] on it. [p] So, yeah maybe it's my fault that I should have done more exercises, I don't know.
Frances: What do you mean your fault?
Linda: Well I didn't...when he said [p] that [p] it, this has happened because, er, because the neck's seized up [Frances. mm] because of the whiplash. [p] If I'd have known early on that exercise would have been good for it, then I would have done it, wouldn't I?
Frances: But you didn't realise.
Linda: I didn't know that. And nobody told me that [p] so that didn't come to light 'til I went to the physio'.

As time went on, the participants would make comparisons about this particular injury with a previous injury, or with others who had sustained a whiplash injury or back injury in order to gain a better understanding of their experience.

Margaret knew from her previous whiplash injuries, what to expect and how to manage the difficulties as they arose:

So, when I realised that I started to get a lot of pain down my shoulder blades and I was getting stiffness in rotating my head. I thought, 'Oh, better get something straight away, take the inflammation down and hopefully it will go away.' [Frances. right] *But luckily from the other injuries I know the worse thing to do is to actually stop moving.*

Linda compared her experience of whiplash injury, with the information given to her by the physiotherapist that was based on his experience of treating whiplash injuries:

*...because there are different strains of whiplash aren't there?
[p] The physiotherapist told me that. He just said, like, you sometimes get whiplash and it's [p] just bad for a couple of week and then you're alright. Sometimes it's like mine where it's bad for, like, up to 12 months or it's that bad that you'll never get right.*

A year later, whilst Linda was reflecting on her injury, the expectation of when she would be recovered changed:

Linda: Mine was supposed to be the middle one. [According to Linda's physiotherapist there were three strains of whiplash injury. Linda had the second one, so she would be recovered from her injury within a year.] [p] Mine was supposed to be middle one.

Frances: Do you think it's the middle one?

Linda: I did think so but you listen to them, don't you, because he's the expert. He told me, I were middle one so.

Frances: What do you think? Knowing what you know.

Linda: Just saying that now, maybe it wasn't.

Over the course of a year Linda has had to change her understanding about the nature of a whiplash injury. Her personal experience of having a whiplash injury has altered the way she understands the injury:

Like I say, I don't think it'll ever go. I think it'll stay like this. Perhaps it might get worse as I get older, I don't know. But it crunches all the time and, like I say, I think I adapt to the neck. I turn all my body around rather than turn my head right around. I turn my body around and face what I'm doing.

As time passed, Martin's injury continued to be problematic and he compared his injury with that of his brother:

...but my brother, he's had an accident and he's been medically certified disabled because of the accident. He's done the same, he's bugged his back. He can't lift heavy objects; he can't drive for long distances. [Silence] So I'm just wondering if I've done same basically.

6.4 Patient as Expert

The participants in this study very quickly went on to become ‘experts’ in understanding and managing the effects of a whiplash injury. They were able to identify and recommend a range of strategies that other patients might use to manage their condition. The participants acquired their knowledge from both formal, that is biomedical, and complementary health practitioners and informal sources such as others who had experienced a whiplash injury and technological sources.

Martin became knowledgeable about his condition through his chiropractor and through people he spoke to who had also had a whiplash injury:

He [the chiropractor] gave me an information sheet about what to do and what not to do. I’ve been told it can carry on for five years this.

When asked who told him that he replied: ‘some other whiplash victims’.

Margaret considered herself knowledgeable about whiplash injury through the information given to her when she had been seen by a physiotherapist, osteopath and a pilates therapist:

I got a lot of information from my Alexander therapist who explained how things worked, and how people reacted to pain and the fact that I had to keep mobile. Because, if I took to my bed every time I had a twinge I would weaken, and my muscles would get very weak, and I would eventually have much worse problems than I have now. So she gave me very sound advice, I think, on self management and, again, my osteopath gave me very similar advice. She gave me a list of exercises I could do: Tai chi, Pilates and swimming.

Margaret had learnt how to manage the associated pain and disrupted movements from her whiplash injury through trial and error: 'I think I've gone through the worst of it and, sort of by trial and error, found out what works for me'.

Through her own experience of having a whiplash injury, Margaret felt she was able to offer the following advice to a person who had just sustained a whiplash injury:

First of all, I'd say go see your GP and see what's available at your surgery, because I do believe it can differ. I was lucky that my physio' did acupuncture, not all physio's do it. So [p] get your self off to the GP get some pain relief, if over the counter medication's not worked. Find out what's available in your neck of the woods and have a go at everything because different things work for different people. So, you know, have physio' manipulate you, try massage, try acupuncture, erm, er, Alexander therapy's quite good [inaudible]. You know, try different therapies until you find one that will ease your pain.

Whilst Margaret saw herself as an expert on whiplash injury, she felt that this advice should primarily come from the health service: '*...predominantly the health service should say to them, right these are different therapies this is what you can do to help yourself.*

Computers and access to the internet have provided another means of gathering information about almost any medical condition that can be easily accessed by the general public. The absence of information about whiplash injury from the doctor led Steph to use the internet:

I'd like to have had [sigh] some kind of leaflet. I mean, I had to find information about whiplash myself. I had to go on the internet to try and find out what to do basically. Whether you could self help, you know what I mean.

Steph found a problem with the information that was available on the internet, as it seemed to be more about claiming compensation than treating the injury: *'There's masses of stuff, but they're all related to claims, which isn't what the objective was'*.

6.5 Whiplash: a minor injury?

In chapter two, we saw that whiplash injury had been classified by the DETR as a slight injury, alongside cuts and bruises that do not require medical attention. It is an accepted fact that injuries such as these do not require attention or treatment from a medical expert. There is an unwritten rule that we do not waste doctors' valuable time on trivia. For example, medical assistance would not be sought for a cut that is seen as being superficial, or even a sprained ankle. This classification would also lead us not to anticipate any particular problems of a lasting nature or for the whiplash injury to be too problematic from the outset. Indeed, if a whiplash injury was compared with a more serious life threatening condition, then it would truly be a minor condition. The term self limiting can also be used instead of the term minor to differentiate those conditions that are expected to last for a short time. Even if we use the term self limiting instead of minor it is still unhelpful. Like the term minor it does not lead us to anticipate any problems of a lasting nature or how long problems might be experienced. It is only when a recovery has been experienced that a condition can be seen as self limiting. However, from the accounts of the participants, a whiplash injury appears to have much more in common with major conditions that have a big impact on everyday life and that might persist for months or years after the injury. The view of a whiplash injury as a minor injury with minimal disruption for our normal everyday experience can change very quickly so the actual experience of the

injury becomes at odds with that view. There is a discrepancy between the expectation about the effect of the whiplash injury and what is actually experienced. At the time of sustaining their whiplash injury, the participants felt that they were either all right or it was nothing to worry about. It was ‘something and nothing’ and it would settle down. This interpretation of their injury fitted with the official classification of a whiplash injury. However, as time went on, the participants’ view that it was ‘something and nothing’ changed:

*I was fine, couldn't feel anything wrong, nothing out of place. Monday was the day of the accident. I was fine the Tuesday. The Wednesday, I started to feel stiff and then the Thursday it just locked up, everything locked up. I couldn't move, I couldn't lift my arm, couldn't look left or right. I tried and I just struggled to get it above head height, my arms.
(Martin).*

*Initially, I thought I was all right, so I wasn't going to go[see the doctor]. But after, a few hours afterwards, my neck started hurting and my back ached all through the evening.
(Linda).*

The difference between Bill’s actual experience and the expectation of what his experience should be, can be seen in Bill’s decision to go to the Accident and Emergency department. Bill went to the hospital because he had decided what he was experiencing from his injury was more than ‘something and nothing’ and he couldn’t manage the effects of his injury by himself:

*Frances: When did you decide to go for medical treatment?
Bill: Well, I went to the hospital [looking at wife] same day didn't I? Because me neck, really stiffened up and me shoulder did [Frances. right] and me back.
Frances: So, was that sort of straight after the accident or...?
[Wendy interrupts]
Wendy: It was during the next day, wasn't it? When he, that he started stiffening up and he went to the doctors as well.
Bill: Yeah I went to the hospital the same day.*

*Wendy: Yeah and they just said take paracetamol.
Bill: And they just said take paracetamol [Frances: OK]
Wendy: And then it got, by about the third day, it got more
and more stiff, and you couldn't move and then you went to
the doctors.*

Bill also went on to see his own doctor a few days later as his whiplash injury continued to become more problematic and once more the discrepancy between Bill's actual experience and the biomedical view of his experience becomes evident. Bill's doctor told him that physiotherapy was needed but there was a three to six month waiting list for the non urgent cases and as he could move, it was non urgent. Bill didn't feel that his symptoms could be regarded as non urgent.

The label 'minor injury' gives substance to the illusion that nothing can or needs to be done even if that is not the case:

*To be quite honest I didn't think from that, there were, from what I was told, that I didn't think there was anything else that they could do. [Frances: right] Because he just sort of said, it was muscular [p] and it heals itself sort of thing.
(Hazel).*

In Linda's case, the minor nature of the injury also seemed to imply that the accident was no more traumatic than if she had fallen and twisted her ankle, even though she had been shocked by what had happened:

*I was so shocked from the accident as well, and upset and everything. It was probably treated, like, if you'd cut your finger or something.
(Linda).*

Chapter Seven: Phase Two: Doctors: Method

In this chapter I will discuss how doctor participants were recruited to phase two of this research study and give a detailed account of doctor recruitment, interview procedure and data analysis.

7.1 Design

The aim of phase two was to answer the following questions:

- How is whiplash injury perceived and treated by professionals?
- Are there differences between how the injury is perceived by the patient and how it is perceived and treated by practitioners?
- What, if any, are the implications of the experience of whiplash injury for healthcare provision?

These had to be translated into questions that would be flexible and allow doctors' personal understanding of whiplash injury to be given. One in-depth semi-structured interview was carried out with doctors between September 2004 and February 2006.

7.1.1 Sampling Strategy

In keeping with phenomenological inquiry, purposive sampling is often used (Crotty, 1996). The main principle behind this type of sampling is the 'researcher's judgement as to typicality or interest' (Robson, 1993:141). I wanted to gain a rich description of doctors' experiences of treating whiplash injury. From my experience of working in the NHS, I thought that Accident and Emergency, Primary Care and Occupational

Health were the areas of expertise that were most likely to provide me with the data that I hoped to obtain.

7.1.2 Recruitment

I asked a well respected doctor who worked in Primary Care for names of doctors who worked within the Huddersfield area of Kirklees and would have expertise in the areas outlined above that I could invite to take part in the study. They were sent an information pack that contained a letter informing them of the study, an acceptance form and a pre paid envelope to return their response (see appendix 14). Recently qualified doctors in postgraduate education at the University of Huddersfield were also informed by email about the study and invited to participate. When I received a reply from a potential participant I contacted them by telephone to confirm their intention to take part in the study, answer any initial queries they may have had and arrange a convenient time and location to carry out the interview.

7.1.3 Sample

A total of twelve potential doctor participants were invited to take part in the study. Eight doctors agreed to take part (see table 5 page 145 for summary). Three doctors were from the hospital setting and five doctors were from Primary Care. The doctors' range of experiences and interests, other than basic medical training, included: child health, disabilities, general practice, occupational health, sports medicine, teaching and trauma. Four doctors declined to take part in the study. The reasons given by the experienced doctors for not taking part in the study were a heavy workload or a lack of interest in the subject matter. I was both surprised and disappointed to find that the doctors who had recently qualified declined to take part in the study. My surprise was

due to the more recent emphasis being placed on healthcare professionals to conduct research themselves. I naively thought that this would have made them more willing to participate. Unfortunately, no reasons were given by this group so I can only assume that they may have felt they had nothing to contribute to the study.

7.1.4 Participant Profiles

To maintain anonymity I have assigned a letter to follow the title of doctor instead of their name. The designation of a letter and not a personal name is a reflection of my professional background and the professional manner in which doctors are addressed.

Dr A is a male doctor whose background is in Primary Care. Dr A works as a GP and also works in postgraduate medical education as a supervisor and lecturer. Years of practice not known.

Dr B is a male doctor whose background is in Primary Care. Dr B works as a GP and has also worked in the Benefits Medical Agency. Dr B has worked as a doctor for 25 years.

Dr C is a male doctor whose background is in Accident and Emergency medicine. Dr C works in an Accident and Emergency department as a Consultant. Dr C has worked as a doctor for 14 years

Dr D is a male doctor whose background is in Accident and Emergency medicine. Dr D works in an Accident and Emergency Department. Dr D has worked as a doctor for over 15 years.

Dr E is a male doctor whose background is in Accident and Emergency medicine. Dr E works in an Accident and Emergency Department. Dr E has worked as a doctor for 15 years.

Dr F is a male doctor whose background is in Primary Care and Occupational Health medicine. Dr F works as a GP, an Occupational Health doctor and is involved in sports medicine. Dr F has worked as a doctor for 15 years.

Dr G is a female doctor whose background is in Primary Care. Dr G works as a GP. Dr G has worked as a doctor for 23 years.

Dr H is a female doctor whose background is in Primary Care. Dr H works as a GP. Dr H has worked as a doctor for 18 years.

Table 5 Summarised doctor profiles

	Gender	Years post qualification	Primary place of work	Relevant expertise
Dr A	M	Unknown	Primary care	Education
Dr B	M	25	Primary care	Benefits Medical Agency
Dr C	M	14	Accident and Emergency	Medico legal work
Dr D	M	15	Accident and Emergency	
Dr E	M	15	Accident and Emergency	
Dr F	M	15	Primary Care	Occupational Health and Sports medicine
Dr G	F	23	Primary care	
Dr H	F	18	Primary Care	

Table 6 Breakdown of doctor interviews

	Site of interview	Duration of interview	Recorded
Dr A	Work	15 mins	Yes
Dr B	Work	22 mins	Yes
Dr C	Work	20 mins	Yes
Dr D & Dr E	Work	35 mins	Yes
Dr F	Work	20 mins	Yes
Dr G	Work	10 mins	Yes
Dr H	Home	10 mins	Yes

7.2 Interviewing

The difficulties I faced with wanting to interview doctors as group were concerned with the practicalities of getting a group of doctors from a variety of locations together. The issue of time was a major consideration due to the time involved in travelling to the venue and the doctors varied work schedules. This aspect meant that it was more practical for me to conduct individual interviews. For this reason individual interviews were chosen to explore the doctors' experiences of treating patients with whiplash injury.

7.2.1 Developing the doctor interview schedule

The interview schedule was developed with the aim of elucidating the doctor's own understanding and treatment of whiplash injury. The schedule was structured around the following questions:

1. Can you tell me what whiplash injury means for you?
2. Can you tell me about your experience of treating whiplash injuries?
3. Can you tell me if you have had experience of treating whiplash injuries on a follow up basis?

4. Can you tell me about a patient who didn't recover as quickly as you would have expected them to and why you think that happened?

7.2.2 Piloting the doctor interview schedule

I piloted the interview schedule on one doctor who worked in Primary Care. The interview was recorded on a minidisk player. Whilst piloting the interview schedule I added a new question that asked the participant about their own thoughts as to why whiplash injuries were said to be on the increase (see appendix 14). This was because their responses might help generate new insights that might be helpful for healthcare providers when planning future service developments. The feedback from this interview showed the questions to be satisfactory. Piloting the interview also enabled me to give a more accurate estimation of the time needed to conduct the interview. I had originally thought the interview would take about an hour but I was able to revise that to thirty minutes. Due to the small number of doctor participants and the fact that no revisions were necessary, the pilot interview was included within the data set.

7.2.3 Interview setting

The factors that I discussed regarding the interview environment in chapter four with the patient interviews, also needed to be considered with the doctor interviews. The participants were given the opportunity to be interviewed at their place of work, the university or their own home. Whilst interviewing people at their place of work can be considered unsuitable as participant anonymity might be compromised for busy healthcare professionals, it might be the most convenient place for the interview to take place. Seven out of the eight participants chose to be interviewed at their place of work. Two of the participants were work colleagues and they requested to be

interviewed together for convenience. This appeared to be as much for me as it was for them. One participant chose to be interviewed at home. Interviewing the doctors at work gave a more formal feel to the interview. I also found that I had to be patient when conducting the interview as on one occasion the doctor was called away to see a patient and then came back to continue the interview, whereas another interview had to finish because of an emergency. This was problematic as it interrupted the flow of data being generated and resulted in a loss of potential data. Even though I understood why the doctor was called away I did find that situation to be extremely frustrating especially when I was unable to resume the interview.

7.2.4 Interview Process

I introduced myself to each participant as a researcher from the University of Huddersfield. The interview began with an explanation about the purpose of the research and its anticipated outcomes, and the participants consent to take part in the study and to record the interview was obtained. The participant was also informed that they could stop, or even withdraw from, the interview at any time and that they were under no obligation to answer all the questions and share that information with me. Once the formality of the introductions was over, I began recording and used the interview schedule to conduct the interviews. During the interview, I used the interview schedule as a mechanism to stop me from taking a medically oriented response and less fruitful harvest of data. This was a very real possibility given my previous working relationships with doctors. Before the interview was completed, the participant was given the opportunity to ask questions or to add anything else they might want to say. I informed them that I would give them a copy of their interview

transcript once it had been transcribed and they would be able to read and comment on the material. None of the doctor participants commented on their transcripts.

7.2.5 After the interview

When I left the interview site, I telephoned a member of the supervision team to inform them that the interview had been completed and that everything was satisfactory. I recorded my general impressions of the interview in my notebook when I returned to my car or as I was sitting waiting for the bus to arrive as the interview was still fresh in my mind. Once I arrived back, I would listen to the recording to make sure it was satisfactory and then place the material in a locked filing cabinet for safety.

7.3 Analysis

As with the patient interviews (see chapter four for a full account), the interview data were transcribed verbatim by me and identifying data was removed from the transcripts. As the doctors' interviews were of shorter duration than the patients' interviews it meant that this process was less time consuming than it had been with the patients' interviews.

7.3.1 Analysis: Template analysis

Analysis and development of the template differed from the process as described earlier in chapter four, with the patients' data set. This was because I used two a-priori themes to structure this template. The two themes that I used were 'whiplash: a minor injury', from the template used in patient analysis, and 'the consultation'. The

consultation was one aspect of the patient's experience that I specifically wanted to examine. This was to see how this might influence the experience of whiplash injury. I selected these two themes to begin the analysis as I thought that they might provide a strong enough structure to produce new insights and understanding about the influences of the first consultation for the phenomenon of whiplash injury. The first interview was used to begin the process of analysis. I thought conducting this analysis would be quite straight forward to carry out and produced the initial template myself before sharing it with my supervisors. I actually found this to be extremely difficult as, once more, I returned to my habitual way of looking at the data. To make matters worse, I realised that I was doing this whilst I was carrying out the analysis but I was unable to stop myself. The template was then applied to the remaining transcripts. My early attempts (see table 7; page 201) produced a very descriptive and medically structured template that did not really tell me anything different about the first consultation. I saw what I was used to seeing. I found it very difficult to let go of my habitual way of looking at the material and found this hard to understand.

7.3.2 The Template

Table 7 Initial template (doctors)

Theme	Lower level theme
Whiplash: a minor injury?	<p>Not as bad as they used to be</p> <p>Only a whiplash injury</p> <p>Inappropriate for Accident and Emergency</p> <p>Self limiting condition</p>
The Consultation	<p>Presentation</p> <ul style="list-style-type: none"> • Seen between day 2 and day 7 after the accident. • Varied 2-3 days • immediately • up to 24 hrs <p>Diagnosis straightforward</p> <ul style="list-style-type: none"> • Easily identified • Usually means pain in the neck • Pain can be elsewhere • Restricted movements • Muscle sprain of the neck <p>Treatment</p> <ul style="list-style-type: none"> • Medication <ul style="list-style-type: none"> Large doses of painkillers Codeine Anti-inflammatories Over the counter medication paracetamol • Acupuncture • Physiotherapy <ul style="list-style-type: none"> Not easy to access <p>Information</p> <ul style="list-style-type: none"> • Neck leaflet • Take them through exercises <p>Early intervention</p> <ul style="list-style-type: none"> • Make plans ahead
Reasons for chronic whiplash injury	<p>Compensation</p> <ul style="list-style-type: none"> • Pressure from claim • Easy money <p>Pre-existing medical condition</p> <ul style="list-style-type: none"> • Poor neck muscles • Over 50 • arthritis <p>Non compliance</p> <p>Reluctance to take strong pain killers</p>

	<p>More severe injury</p> <p>Mental state</p> <ul style="list-style-type: none"> • depression <p>Occupation</p> <ul style="list-style-type: none"> • physical jobs • Car manufacturers <p style="padding-left: 40px;">Seatbelts, head restraints</p> <p>Issues around the accident may delay</p>
Increasing incidence of whiplash injury	<p>Compensation culture</p> <ul style="list-style-type: none"> • Move towards American system • Document injury • Advertising compensation claims • Insurance company <p>More road accidents</p> <p>No increase in cases seen</p> <p>Sickness, absence</p> <p>Seatbelt legislation</p>

As I pondered on this, I wondered if my difficulties might be like those faced with learning a new language. My habitual attitude was my first language. I was so familiar with it I did not have to think about what I was doing, whereas having to suspend my habitual view was like learning a second language. It was easier, but not fruitful, for me to stay with meanings from my habitual attitude. This meant that it was important for me to keep asking myself what else this might be saying and what else it might mean. The next version of the template was still very descriptive and remained medically oriented (see appendix16). This was an extremely frustrating time as I was getting a glimpse of something that was quite elusive to capture. As I continued to reflect on this situation, I began to wonder if this was as far as I could go. I was nearly at the point where I had decided this was it and I could not do any more when, suddenly, it occurred to me that I was not really applying the hermeneutic of suspicion with the doctors' interviews, I was being uncritical and accepting their accounts at face value. I realised that I was approaching the data in exactly the same way as I would have approached the doctor when I was a nurse working in a

heirarchical setting. This meant that I tended to defer to the position the doctor held within the heiracrchy. Whilst the doctor – nurse relationship is considered to be equal in my experience a power differential often comes into play where the nurse takes a less equal position. As I thought more about what this meant, I became aware that I also felt as if I was betraying their trust and was using the data under false pretences. This insight really transformed my way of thinking about the data. I knew that was not the case but it felt like that. When I started this project I had thought it might have been the treatments themselves that were an important influence on whether or not patients made a full recovery. As I was reflecting on the interventions the doctors used, I suddenly realised that the interventions themselves were not especially meaningful. The intervention either worked or it did not work. It was the particular way the doctor responded to a presentation of whiplash injury that was meaningful for the experience of whiplash injury. It was the doctor's response that might have potential implications for practice. The doctors' response became one of the identified influences of healthcare provision during the first consultation and will be discussed further in chapter eight. Once I had realised what I had been doing, I then felt able to re-code the data more phenomenologically. The final template (see table 8; page 204) provided me with the structure to write up my findings.

Table 8 Final template (doctors)

Theme	Lower level theme
<p>Expectations re what patient will experience</p>	<p>Expectation of lack of problem for patient</p> <ul style="list-style-type: none"> • Whiplash injury as known quantity <ul style="list-style-type: none"> - Associated with car accident - Specific pain and stiffness - Immediate response, minor injury <p>Expectation re. minimal need for intervention</p> <ul style="list-style-type: none"> - Patient should get better with little or no intervention <p>Not as a patient who also experiences a psychological reaction to the accident</p> <p>Expectation of possible problems for patient</p> <ul style="list-style-type: none"> • Medical problems <ul style="list-style-type: none"> As a patient who might become depressed. As a patient for whom there is a small chance they will require extended medical interventions Not just a patient with neck problems • Social problems <ul style="list-style-type: none"> As a person whose symptoms might interfere with work <ul style="list-style-type: none"> Manual work Care Not as a person whose symptoms might interfere with domestic responsibilities <p>Additional factors impacting on patient's experience</p> <ul style="list-style-type: none"> • As a patient who has problems tolerating certain medications <p>As a patient who might have other health issues</p>

Template continued

Theme	Lower level theme
<p>What Patients do about their whiplash</p>	<p>Ulterior motives for focus on whiplash injury</p> <ul style="list-style-type: none"> • As a patient whose injury is a construction of injury compensation systems • As a person under pressure to make a claim • As a person seeking justice • An opportunity to make money <p>Patient has personal responsibility for extended problems</p> <ul style="list-style-type: none"> • A patient who is reluctant to take medication • As a patient who does not take doctors advice • A person who develops illness behaviour • A person who might adopt the sick role <p>Inappropriate use of Accident and Emergency</p>
<p>What doctors do</p>	<p>Deal with patients</p> <ul style="list-style-type: none"> • To see patients with whiplash injury • Identify and document the injury • Prescribe treatment <p>Encourage patient to help self</p> <ul style="list-style-type: none"> • Advise and reassure • Encourage to keep mobile <p>Use NHS resources appropriately</p> <p>Use knowledge and personal experience</p>

Chapter Eight: The doctors' thematic analysis

In this chapter I present the themes that were identified through the template analysis of the doctors' interviews. Only one method of presenting the doctor participant findings is used as this is deemed sufficient to illustrate the doctors general approach to the whiplash patient group and there was also less of an holistic picture of their accounts needed. Having discussed the development of the template earlier, and for the sake of brevity, I refer the reader back to chapter seven for a detailed account of how the themes were derived. As noted earlier, the themes were arrived at through a continual process of reading the texts and modification of the codes. The codes are also represented hierarchically so that the highest level codes represent broad themes in the data whilst lower level coding represents more narrowly focused themes. Three overarching themes were identified from the template. These are; expectations regarding what a patient will experience, what patients do about their whiplash and what doctors do.

8.1 Expectations regarding what patients will experience

This theme looks at the doctors' expectations of what their patients should experience with a whiplash injury. This theme demonstrates that the doctors' accounts revealed two different expectations about whiplash injury. The first, anticipates a lack of problems for the patient. However, during the course of the interviews the doctors began to refer to the fact that patients may well have problems. This is interesting as the doctors appear to uncritically apply predetermined criteria when identifying what a specific condition involves before they are able to think more critically about it and can begin to draw on their own personal perceptions.

8.1.1 Expectation of lack of problems for the patient

The doctors' initial response to whiplash injury showed a concrete objectifiable orientation towards an entity that was readily identified. The doctors' immediate response to the question of 'what does whiplash injury mean to you?' was to respond by drawing on a categorization that gives a simple definition of whiplash injury. This simple definition leads to the expectation that whiplash is a minor condition and, as such, would not be particularly problematic and can be easily managed. Some doctors went into some detail about the type of car accident that was typical of the collision that would produce whiplash injury:

It's usually a car accident. It's usually somebody who is in a stationary vehicle and a heavier vehicle hits them from behind. Usually when the second vehicle hasn't noticed that the traffic lights haven't changed or that some obstruction occurs at a roundabout.
(Dr A/GP & Lecturer).

Whiplash injury was recognised through specific symptoms of pain and stiffness that were related to the neck and readily ascribed to whiplash by all the doctors:

They've usually got gross restriction of flexion and some restriction of rotation. If they've been hit slightly obliquely, then they may get a lot of restriction of rotation and they may have pain lower down their backs as it's quite common to tear little bits out of the erector spinal muscles lower down or even snap off transverse processes from the vertebrae. So it can present with a whole range of levels of pain. But mostly in the neck, mostly on attempting flexion.
(Dr A / GP & Lecturer).

Some doctors also suggested that there were other symptoms that patients might also experience and that there could be variability with the onset of symptoms:

Most of the symptoms tend to be related to the neck although you can get other associated symptoms such as headache and dizziness. You can some time get pain referred down to the lower back as well as specifically in the neck.
(DR C/ A&E).

Looking at these descriptions of the physical symptoms that patients experience makes me think how is it possible to see the injury as non problematic. How can you not see that it will create immediate difficulties for patients? And it does not matter whether or not it is for a few days or longer that the whiplash injury will be experienced as problematic by patients. But as we will see later this is not the case.

The delay between the injury occurring and the onset of symptoms meant that there were some differences between the doctors' expectations of when patients might be seen. The doctors who worked in A&E were most likely to see patients on the day the injury occurred. In contrast the doctors who worked in Primary Care expected to see patients up to a week after the injury occurred:

*People that I've seen tend to present several days later after the accident. Either they might have gone to casualty at the time or they might have gone a day or so later and then they come to me.
(Dr H/ GP).*

8.1.2 Expectation of minimal need for intervention

The authority vested in the simple definition of whiplash injury as a minor condition, is fundamental in underpinning the doctor's expectation that the patient's need for interventions would be minimal:

*There's definitely a very acute stage [p] where the majority of the problems are dealt with or resolve spontaneously.
(DR F/GP & Occupational Health).*

The interventions advocated by the doctors were reassurance, some form of pain relief and active movements to manage whiplash injury. The expectation of the patient

requiring minimal intervention is also reinforced when the patient does not return for further advice:

Dr H: I see them once and say if they are having any trouble still, to come back.

Frances: And do they generally come back?

Dr H: I'd say not.

(Dr H/GP).

The doctors' perception of the need for minimal intervention and seeing whiplash injury as a short term condition, also suggests that the doctors see whiplash as a condition that patients can, and should be able to, manage themselves. This stance might also be taken to mean that there should not be any further implications for the patient's wellbeing.

Dr B, as well as seeing whiplash injury as a condition of short duration, also understood the condition as one that patients should be able to manage themselves. This view leads him to discourage patients from returning to see him if they experience any problems:

I think if I was to ask them to come back for a follow up that might perpetuate the idea of it. Whereas, I think it's something people can and should be able to work through.

This stance might also indicate that Dr B was aware of and applying the back to work concepts (Waddell and Burton, 2004).

Discouraging patients from returning might also be seen as a form of protection against the doctor having to face feelings of uncertainty and not knowing what to do when their professional expectation is unfulfilled.

None of the doctors mentioned the possibility that their patient might also have had a psychological reaction to the accident and experience symptoms of psychological distress. In the first instance, the doctors focus on whiplash injury as a strictly physical condition that does not have any psycho-social implications. This is an important point to bear in mind as the development of psychological disturbances such as travel anxiety or post trauma stress does not even require the patient to have a physical injury.

8.1.3 Expectation of possible problems for the patient

As the interview progressed, and without prompting from me, some of the doctors went on to express a perception of whiplash injury that meant some patients were seen to have long term problems that have psycho-social implications. I think this second and more critical perception could only be revealed after the doctors had been able to give an account that was framed around the categorization of whiplash injury as a physical injury. This response showed an awareness that whiplash injury could prove to be problematic for some patients who might also require extended medical interventions. Three of the doctors interviewed were not able to recollect treating a patient with whiplash injury who either experienced problems or failed to recover from the injury. However, they were all able to give medical and psycho-social reasons to account for the possibility that their patients might experience problems and require extended medical interventions.

Medical problem

It was interesting that once again the doctors' immediate response was to draw on underlying medical conditions to explain why whiplash injury might be experienced

as problematic before consideration was given to psycho-social issues. One reason for this might be due to the doctors feeling more comfortable when dealing with medical matters as opposed to psycho-social issues.

Arthritis is a degenerative medical condition usually associated with age and was given as one reason why whiplash injury might be problematic for the patient:

*It might be because of previous pathology. It might be that the patient has already had got a degree of wear and tear to the bones in the neck and the whiplash was the last straw.
(Dr G/ GP).*

*Obviously if they've got any underlying osteoarthritis, you know that could make that problem worse, er, or if they had, sort of, an arthritis problem elsewhere it could cause a flare up.
(Dr H/GP).*

A person's age is also implicated. However, it is not clear whether this is because of the association with pre-existing medical conditions or that getting older might just means you are more likely to experience problems with the injury:

*...if they've got a chronic health problem with their neck. They may be over 50 and have arthritic problems in their neck, for whatever reason, and that may flare them up a bit. They may either blame it [the whiplash injury] or it may actually give them a downward course with their health and we end up seeing them fairly regularly.
(DrF/GP & Occupational Health).*

Dr H [who has had little experience of treating acute whiplash injury] recalls that many of the patients that she has seen with neck related problems have often had a whiplash injury at some point:

I've seen, sort of, many times over the years that sometimes in their history, not that I've necessarily been involved with, they've had a whiplash injury, it transpires.

Psycho-social issues

The doctors referred to a range of psycho-social issues that might be associated with whiplash injury, namely depression and stress which could also be considered as a medical problem. However these are psychological conditions and for that reason I have included them within psycho-social issues.

Depression and Stress

Depression and stress were also associated by the doctors with whiplash injury and the lack of improvement in some patients:

*It is related to the patient's mental state. Patients who are depressed is another reason why it's [the whiplash injury] not improving.
(Dr C/A&E).*

It was suggested that depression and stress could become intertwined with the injury:

*...then there might be some background psychological factor in the patient. They've got inter-current illness particularly stress, depression, er, issues going on there.
(Dr F/GP & Occupational Health).*

It was also proposed by one of the doctors that the patient needed to be understood holistically and more importantly the injury should not be viewed in isolation from the accident:

*It may be that there were other issues around the accident. People with whiplash shouldn't be looked at as just a patient with a neck problem, they are people who have been in accidents, people who may have other issues around the accident which will delay their recovery.
(Dr G/GP).*

Dr H (GP) proposed that the chronic illness and the effect of an injury can also lead on to psychological difficulties. However, she was the only doctor who mentioned this:

...I mean, as with any sort of injury or anything that causes you pain, sometime then that can lead onto other illness. Er, sometimes there are things that you can't do that can kind of lead people to, erm, to other things like depression and that sort of thing.

This appears to imply that there might be a potential implication for practice as practitioners might also need to consider and assess the patient for psychological injury when a patient first presents with a whiplash injury.

Incapacity

The doctors often saw that whiplash injury might be incapacitating through the experience of pain, the effect on movement or a combination of both. The incapacitating effect of whiplash injury was recognised when it interfered with the patient's capacity to carry out their usual occupation:

*The type of job they do, er, if they've got a particularly physical job, that often involves movement of the neck, say they are a care assistant, the pain may persist and they may not go back to work as quickly.
(DR F/GP & Occupational Health).*

It is interesting that no reference was made by the doctors as to how the whiplash injury might be incapacitating on daily activities not associated with work. Dr F uses the example of a care worker who would not be able to carry out his/her normal range of duties because of the restrictions to the range of movements that involve the neck. In chapter four, we looked at how a stiff neck might affect a movement involved in something as simple as reaching out for a cup of tea. Parents of young children would

carry out a similar range of movements in caring for their children. On that premise they too would suffer from similar difficulties to the care worker. A parent with a young baby might find that the simple task of changing a nappy or picking up the baby becomes extremely difficult to carry out. Many of the tasks that people carry out around the home involve movements of the neck. All the upper body movements would involve the neck to some extent. None of the doctors make any reference to difficulties that are concerned with the situation at home. The lack of reference to the home might be because the doctors do not see this as being important or worth discussing. This could be seen as perpetuating and reflecting the way low value continues to be placed on domestic work. It is also possible that the effect of incapacitation in paid work is seen as a possible link with compensation claims.

The incapacitation that their patients might experience from whiplash injury was often seen as a result of experiencing pain with movement. This is different from the incapacitation being associated with the loss of movement due to stiffness. The pain was responsible for reducing the range of movements that a patient was able to make: ‘The idea is that I keep them pain free, so that they can try and regain their full capacity of movement’ (DR F/GP & Occupational Health).

I tend to offer people who have stiffness and pain acupuncture on the first meeting and if they don't want to do that, then I give them a large dose of painkillers and suggest that if they can't become mobile without pain very quickly they should move on to some other method such as physiotherapy or acupuncture.

(DR A/ GP & Lecturer).

8.1.4 Additional factors impacting on patient experience

The doctors recognised that there was one particular factor that was not related to the whiplash injury or accident that also impacted on the patient's experience. This factor was related to the possibility that the patient might have problems with tolerating certain medications. Problems that are created through the use of medication or other treatment that doctors might use is also known as iatrogenic:

*Some people can't take the anti-inflammatories due to a bad stomach and are slow at coming forward to say, well, can I have something else?
(Dr F/ GP & Occupational Health).*

Dr F is also suggesting that patients have a responsibility to actually challenge the doctor's recommended treatment if they know they are unable to tolerate a particular medication. Moreover, the patient has a moral responsibility to inform the doctor during the consultation or to go back and let the doctor know that their treatment is not working. In that situation the patient is at fault not the doctor.

From the accounts that I have presented so far it becomes quite clear that some of the doctors are not aware that whiplash injury can be more than a physical condition. The psycho-social issues and contradictions that have been teased out from these interviews also challenge the idea that whiplash injury is just a minor injury.

8.2 What patients do about their whiplash injury

This theme looks at how the doctors were suspicious of their patient's motives in focusing on whiplash injury and how the patient had some responsibility for their predicament of experiencing ongoing problems.

8.2.1 Ulterior motives for focus on whiplash injury

The issue of compensation was raised by the doctors as a factor that might play a part in the patient's experience of whiplash injury. The notion of compensation and malingering is discussed in detail in chapter two. The issue of compensation is complex and to some extent how the issue of compensation is seen is dependent on the doctor's place of work.

All the doctors suggested that the possibility of compensation was one reason why patients presented with a whiplash injury. However there was a difference between the doctors' accounts of the perceived increase in workload that this generated. The doctors who worked in the A&E department suggested that this was the reason why they now saw more whiplash injuries than they used to do:

*I think we find that there is quite an increase in the people that are attending [A&E department] since, when the hospital starts charging the insurance company for their money and, er, people for the last few years. I mean, I have worked in the NHS for the last 13 years and I have found that people are trying to get towards the American system, of compensation and legal things and, er, blaming. Sometimes you see them families, families with 6 or 7 people, all of them - no injury.
(Dr D/A&E).*

In this study, the perception of doctors in general practice differed from their colleagues in the A&E department as they did not feel that there had been a noticeable increase in the number of patients presenting to them with a whiplash injury:

*I didn't know that there were more whiplash injuries around today than there were before. I certainly had one gentlemen who came in who said, 'I know I have got a whiplash injury. I know it's trivial but I'm going to sue therefore I want it recording.' So, some of the reason is monetary.
(Dr G/GP).*

The reason for this difference is most likely to do with the way GPs usually just see patients from their own practice population. Like the doctors in A&E, they did suggest that some patients went to see them specifically with a view to pursuing a claim for compensation but also felt that patients generally wanted to have their whiplash injury documented in case it was needed in the future:

*I think people are more keen to document it, in case, not necessarily to pursue a claim, but to have it on record in case something crops up later when they may want to go back to it.
(Dr F/GP & Occupational Health).*

The doctors suggested that society and people's individual attitudes were changing towards claiming compensation for pain and suffering. This change was reflected by the media as companies advertised on television, in the papers and magazines and patients were encouraged by friends and relatives to make a claim. As a result of this people were often pressurised into making a claim: '*It seems very much related to the compensation culture. But there are certainly more lawyers than there were before*' (Dr B/GP).

*And there are now quite a lot of firms, insurance firms, who are pushing the people to claim in order to get compensation and, er, and the majority of those people they come in here [A&E department].
(Dr D/A&E).*

According to the doctors, the pressure from insurance companies meant that people were more willing to claim compensation for their pain and suffering. This has led to it becoming more acceptable for people to use any opportunity to make money from anything that might cause discomfort, no matter how trivial the complaint might seem.

A perceived disadvantage to claiming compensation was that the process of claiming compensation led to the whiplash injury becoming a chronic condition, by keeping the injury to the fore of the patient's experience, and this inhibited their recovery:

*I think by saying whiplash people, er, tend to think about compensation and I think that doesn't help people's recovery. If they've always got, in the back of their mind they're likely to get some money out of this at the end of the day.
(Dr C/A&E).*

*I think there is, erm, a pressure to, er, [p] to follow litigation and, erm, that's adverse and, er, it I'm sure it takes your mind off the essential thing which is getting absolutely fit as fast as possible.
(Dr A/GP & Lecturer).*

Claiming compensation was also seen to be detrimental to a patient's well being. In this case we see how the doctor perceives the patient has become fixated on what they perceived to be an injustice:

Dr A: The outstanding one was somebody who was obsessed with the injustice of it and that the person who went into the back of them should have seen and shouldn't have ruined their vehicle and shouldn't have ruined their life and I couldn't get that person to concentrate on getting better. It was outstanding that she was obsessed with the injustice and she spent [p] a great deal of her effort in the litigation and to my knowledge she's never got better.

Frances: Never got better?

Dr A: I just, I almost wanted to shake her and say, 'Get moving!' because she wouldn't listen to me about that and she wanted me to record how bad she was for the legal purposes and to recognise, I suppose, how unfairly she'd suffered.

(Dr A/GP & Lecturer).

Once again attention is drawn to the existence of a moral dimension that is bound up in roles and obligations. I think that this highlights quite graphically the tension between the doctor's focus on the medical problem and the patient's focus on the injustice of her situation which is a psycho-social issue, and her need to have that feeling validated. This situation points to the doctor feeling a sense of impotence and

powerlessness as he is unable to do anything about the injustice, but would be able to treat the physical problem if only the patient would listen to him and do as she was told. This might be one reason why the doctors seem reluctant to focus on psychosocial issues.

In a minority of cases, making a claim for compensation was also seen in a positive light when it was seen as enabling patients to gain access to treatment such as physiotherapy that might otherwise prove difficult to get on the NHS:

*I will try and refer you on the NHS and you might get seen relatively quickly but, you know you may consider it appropriate to pay for your treatment and explore how to claim that cost back if it is appropriate.
(Dr F/ GP & Occupational Health).*

8.2.2 Patients sometimes make it worse

The doctors also suggest that patient's actions might play a part in the development of extended problems. When this happens, the patient might be seen as having personal responsibility for their difficulties and this might result in the doctor making a judgement about the patient's actions.

Patients who ignore the doctor's advice

When doctors are faced with a condition that is not resolving or conforming to their expectations, they have to question why this might be happening. One aspect of that questioning is related to patients' behaviour and whether or not the patient is seen to carry out the doctor's instructions. Failure of the patient to carry out instructions relating to medication and other interventions was seen as reason for extended problems:

...what also delays it, some people are reticent to take pain killers and to comply with the exercises [p] and get gradually worse. (Dr F/GP & Occupational Health).

If they are not following the advice that we give them or they're not using their, their painkillers regularly, acute whiplash injury may change into chronic whiplash. (Dr D/A&E).

This might lead the doctor to see the patient as being responsible for their problems as the patient has chosen to reject the advice and therefore it is their own fault. This is similar to a parent who says to their child 'you only have your self to blame. If you had listened to me and had done as you had been told you would not be in this predicament'. This seems to suggest that the doctors see patients as people who should do as they are told and not think for themselves. The issue of who has power and control is recognised as an important influence of the doctor-patient relationship that has implications on whether or not the patient carries out the doctor's instruction (Trostle, 1998; Wertheimer and Santella, 2003). The doctor, when dealing with a patient who does not carry out their advice, might be more inclined to see this patient as being difficult to deal with and an immediate tension within the doctor-patient relationship might be created.

Illness behaviour and the sick role

The doctors suggested that some patients were seen to develop what was described as illness behaviour. This is behaviour that occurs as a direct response to the symptoms experienced by the patient. The patient is seen as holding themselves in a particular way or not carrying out a particular movement; for example, instead of just turning the head to look around, the upper body is turned as well:

I don't want, want to, to try and get them into a pattern of illness behaviour where they're stiffening their neck and they're holding themselves rigid. I think it's important to keep them moving.
(Dr F/ GP & Occupational Health).

Here we see that the patient, in anticipation of the pain they will experience by moving, begins to hold themselves in such a way as to limit the pain they will experience. The problem with this is that it perpetuates the problem. In other words, it becomes a circle that the patient is either unable to, or does not want to, get out of as it helps them deal with their problem. This suggests that Dr F sees the stiffness and rigidity as being under conscious volitional control and that they could choose to do something about it. There is a moral issue here as the patients are stiffening up and holding themselves rigid when in fact they should be doing something else. The patients are at fault and being blamed for what they are doing.

In illness behaviour the fact that the patient is not moving properly is understood as a consequence of the stiffness and not as a failure on the part of the patient to carry out exercises. The development of illness behaviour is also seen as a consequence of the patient not being given any treatment when first seen by a doctor at the A&E department:

...and I think I see a lot of people who haven't particularly been the ones who have bounced through casualty have been given nothing for a few days and they are harder to treat, they seem to have then stiffened up.
(Dr F/ GP & Occupational Health).

It would appear that having illness behaviour does not automatically mean the patient adopts the sick role; it just means their behaviour is different from the way it was before the injury occurred. However, some people with illness behaviour might go on to adopt the sick role.

Dr B suggests that some patients take on the sick role more readily than other patients.

It is not clear whether or not he means that whiplash injury is used as an excuse to have time off work or that the patient has problems in carrying out everyday activities:

...then there is the psychological aspects to it. Some people will get medicalised far more readily and they'll take on the sick role far more readily than others.
(Dr B/GP).

Doctors legitimate the sick role by giving patients a sick note to absolve them from their normal occupational roles:

...then they come to me for a sick note. There's a variable amount of time that they'd want off work or they need to have off work.
(Dr H/GP).

...they could want to document it if their employer checks up on why they were off sick if they want a note. Er, their employers may be a bit tighter with their sickness absence management, they want it in writing therefore they have to document it with their doctor to get the certificate.
(DR F/GP & Occupational Health).

Dr B has also intimated that whiplash injury is a condition that is perpetuated through doctors colluding with patients and providing sick notes. To support this claim, Dr B makes a specific reference to a particular piece of work he looked at with colleagues in a former work setting:

Dr B: I did used to work in the Benefits Medical Agency service and we looked at disability analysis. And we did see, there's one country in the union, that doesn't actually recognise it what so ever. They won't accept it as a claim for incapacity and so that country doesn't have it [whiplash injury] and no people present with it.

When I asked for more information about this Dr B reduces the emphasis of his own knowledge by referring to it as anecdotal evidence:

Frances: Right. So do they present with other things then?

Dr B: I don't know.

Frances: So it's just, they don't present with it?

Dr B: Yeah, it's just purely an anecdotal tale.

Here we see how Dr B is claiming to know more than he actually does and then he stands down when he realises that what he says is not factual.

Inappropriate use of the Accident and Emergency department

The doctors who worked in the A&E department were quite clear that they saw whiplash injury as no more than a minor injury. Whiplash injury was a source of dissent to doctors working in the A&E department. Dr D felt that a whiplash injury was an inappropriate injury for medical attention to be given by the A&E department, even though it occurred as a result of an accident. He felt that it would be more appropriate for the whiplash injury to be seen and treated within Primary Care. We saw earlier in chapter two how a whiplash injury was included in the definition of slight injuries, requiring either roadside treatment or no medical treatment at all:

I feel sometimes that why on earth do we see them in A&E, why can't they be checked by their GP? I mean, it is not something they need an x-ray for and the whiplash is easy to diagnose, and it could be treated. But, because it is trauma go to the A&E.

(Dr D/A&E).

The circumstances of the RTA might also lead paramedics to treat the patient as a person who should be seen as an emergency, but on examination the symptoms from the doctor's point of view do not accord with this. The injury is then seen as 'just a whiplash injury.'

Sometimes we give them, er, I mean ambulances are over protective on these cases. They get them here on a spinal board with a hard collar, tape on their head and then we examine them and sometimes, even we, don't send them for x-ray. Because, if you examine them properly and find out their neck is ok, it's just a whiplash injury. (Dr D/ A&E).

The doctors' view that patients with whiplash injury misuse the A&E department is confirmed when patients do not attend immediately after the car accident or choose to leave the department if they have to wait a long time. It is interesting that a patient leaving the department to return when it is quieter is not seen as someone who might be trying to reduce pressure that doctors might face from a high workload:

The majority of them [patients] with a whiplash they came after 24 hours. Some of them, they come when waiting time is 3 or 4 hours. They go [if it is busy] and they come [return] when it is the quietest time. (Dr E/ A&E).

Another reason why the doctors working in the A&E department might feel that the department is misused by these patients, is directly related to whiplash injury being a minor injury. In the A&E department the doctors are dealing with life threatening conditions and in comparison whiplash injury is truly a minor occurrence so that these patients are seen as diverting the staff's valuable time away from the business of dealing with what is classed as an emergency.

8.3 What doctors do

This theme looks at what the doctors do when dealing with patients and the way they perceived their role with the patients they see.

8.3.1 Deal with patients

All the doctors in this study understood their role involved seeing patients with whiplash injury with a view to identifying and documenting the extent of the patient's problem and prescribing treatment. Identifying, documenting and prescribing treatment were all standard things that the doctors did with these patients as indeed they do with other conditions. Part of the reason why doctors do what they do is in anticipation that the patients may need documentation:

*They come in with pain and stiffness and I have a look at them. Check the movement record, the movement. So I record the actual measurements.
(Dr B GP).*

*... 'And I want to be checked out and my injuries documented', either they say that explicitly or it's implicit in the consultation. People seem keen to document their injuries.
(DR F GP & Occupational health).*

Dr A (GP & Lecturer) was also trained in giving acupuncture and would offer acupuncture at the outset to his patients:

I tend to offer people who have stiffness and pain acupuncture on the first meeting and if they don't want to do that, then I give them a large dose of painkillers and suggest that if they can't become mobile without pain very quickly they should move on to some other method such as physiotherapy or acupuncture.

This highlights one way in which the doctor's personal interests and experiences can lead to inequality within service provision.

Two of the doctors also thought ahead by anticipating that a particular treatment might not be effective, which led them to produce alternative plans that could be used to do different things:

I tend to make plans ahead saying, on the basis of how you are now, maybe you'll just want to take some paracetamol. But if you're worse tomorrow, you're going to want some other things and if you're still not able to move, then I want to see you again. So I tend to build in a fairly rapid escalation of treatment. So to me, it's intervene early, chemically and physically.

(DR F/ GP & Occupational Health).

The doctor's accounts reveal how the particular position that the doctor takes towards whiplash injury appears to be an important part in the decision making process that underpins the individual doctor's response.

Dr B (GP), as noted earlier, takes the position that whiplash injury is a self limiting condition and he responds to a patient by 'doing the standard thing(s).'

...advise simple analgesics and some times anti-inflammatories and encourage movements of the neck and discourage them from using collars either hard or soft.

In contrast, Dr F (GP & Occupational Health) is 'responding to the particular':

They have short courses of non steroidal and they sometimes come out of casualty with soft collars and things which we try and avoid if we can. We, encourage them to use their neck normally and often they don't come back. And we then see a very small number of patients who go on to have much more chronic problems with their neck. In which case it's much more about, er, referring on to physiotherapy and trying to get further therapies for them, rather than the acute prescribing phase which would probably go on for the first 4-6 weeks.

What we see here is quite clearly that doctors take different positions.

8.3.2 Encourage patient to help self

From the doctors' accounts there was a perception that patients can, and should, be encouraged to self manage their whiplash injury. This means that patients are actively encouraged by the doctors to manage their own care. The reason for this might, in

part, be due to the way there is a general expectation within society that people can, and should, be able to manage those complaints and ailments that are deemed by the medical profession to be minor. The doctor's obligation and responsibility in the case of whiplash injury is perceived to end at the first consultation and responsibility for care is passed back to the patient. Self care has also been seen as one way of reducing demand placed on doctors' time and other healthcare resources (Department of Health 2005). This might be one reason why there has been a turn away from doctor management to patient self management. This is particularly noticeable with patients who have a chronic condition (Gately et al., 2007). The emphasis on the patient's ability to manage their injury was shown through the doctors reassuring their patients that there was nothing seriously wrong with them and encouraging patients to self manage their whiplash injury.

Dr F (GP/ & Occupational Health) reassures his patients by giving an explanation of what happens with a whiplash injury to help them understand their experience:

People always look at you fairly shocked when you say that you know your head weighs [p] 5 – 7 lbs something like that. And, er, it's like a small bag of potatoes and they think, cor that's quite heavy, and it's been, suddenly been decelerated or accelerated in the course of an impact. It's obviously going to damage the things that are anchoring it to the rest of your body i.e., your muscles and your bones. And they look at you a bit shocked when you say that. Er, erm, I think then they begin to realise why it might hurt.

The doctors also encourage patients to keep mobile and carry out exercises to maintain a normal range of movement. This is achieved either by giving written information or by taking on a quasi physiotherapist role:

Normally with patients suffering from whiplash I'd hand a leaflet about neck mobilisation and I'd normally demonstrate it to them, er, because I'd normally have asked them to go

through a full range of movements, point out where they are restricted and I ask them to repeat that several times a day. And, er I normally say, my verbatim is, 'Do it like you're doing Tai chi. Going ever so slowly so you are stretching and not tearing and try and get as far as you can go in one direction. Wait a few seconds for the tension to die down and just see if you can push it a little further.' And I'd instruct them in flexion and extension. Lateral flexion and rotation - both sides.

(Dr A GP & Lecturer).

I think this is a demonstration of how, in a sense, the doctor might not see their professional responsibility and obligation as being wholly discharged following the initial consultation for whiplash injury. It is possible that this demonstrates a way in which the doctors might be able to reassure themselves that they had done all they could.

8.3.3 Use NHS resources appropriately

The doctors are aware of their responsibility for using NHS resources wisely and try to treat patients within the constraints that are placed on them. Doctors also understand that they are supported in their role of providing appropriate treatment for patients by being able to access other services or resources. Physiotherapy was one resource that was seen as being beneficial when pain and movements were particularly problematic, in what was said to be the acute or early phase of the injury. However, being able to refer a patient with a whiplash injury for physiotherapy on the NHS was more easily said than done. Whiplash injury as a minor injury would be a low priority for the allocation of physiotherapy resources:

My next port of call would be to physiotherapy, to try and get the neck pain settled through physiotherapy. Our problem with that is that the physiotherapy waiting lists are quite long. So, whilst it might be ideal to have some physiotherapy in the initial stages of the injury, we don't do that.

(Dr G/GP).

Dr G's action also reveals the requirement placed on Primary Care services to prioritise and limit access to secondary services. The prioritisation is justified by a referral that is based on patient need. This definition of need is often determined by the department that is responsible for the particular service provided and not the doctor. Doctor G is aware that need has to be realistic and not idealistic: '*We try and deal with people as much as we can, before we refer them to secondary services*'.

Doctors are also reminded about the need to use scarce resources with care through regular updates from the service that has been used:

*I have a vague notion that it may be fairly easy to get for acute injuries. But we're forced to continually, by feedback forms, saying, you know, you're referring this much, not to refer too much. So we tend to only refer the ones that have bounced [patients who have not recovered as expected] and by then they are not acute.
(Dr F/ GP & Occupational Health).*

Dr F's (GP & Occupational Health) comment about his 'vague notion' suggests that actually he may not be the best person to treat these patients. I do not really know what to do for these patients, but I do know that a physiotherapist would be more appropriate:

I will try and refer you on the NHS and you might get seen relatively quickly. But, you know, you may consider it appropriate to pay for your treatment and explore how to claim that cost back if it is appropriate or, alternatively, you try and [p]either pull a favour in or make it fairly explicit on the physio.

Dr F (GP & Occupational Health) demonstrates how he tries to get around the issue of accessing physiotherapy by suggesting the patient might pay and then reclaim their

expenses back if it was appropriate to do so. Alternatively he would try and use his personal influence to achieve what he considered to be appropriate treatment.

8.3.4 Use personal experience

Whilst all the doctors used their professional knowledge and experience of understanding whiplash injury, two of the doctors also drew on their own personal experiences of whiplash injury to support their understanding of what whiplash injury might be like for patients:

*I had a whiplash injury. Mine was utterly trivial because I was in a Volvo, er, 940 estate and the car that went into the back of me at the traffic lights was a Renault Megane or something like that.
(DR A/GP & Lecturer).*

Dr A's (GP & Lecturer) own experience of whiplash injury supported his view of the minor nature of the condition. Dr A then goes on to detail the circumstances of his accident:

That car was ruined. There was oil brake fluid and water pouring out of it and mine had literally not got a scratch on it. So, I'd only got a bit of a thump and a minor movement.

He points out how the other driver's car bore the brunt of the damage whereas both he and his car were relatively unhurt which leads him to describe the situation as trivial.

Although Dr A describes his experience of whiplash injury as trivial he is not saying that the symptoms in themselves are necessarily trivial. This is shown by the way he emphasises the importance of treating the symptom pain:

I think the crucial thing from the GP point of view is that they need adequate pain relief early and that means usually encouraging people to take tablets who don't want to.

His experience also provided him with a view that litigation played a big part in patients experiencing protracted symptoms:

I happened to mention it to a friend who is a barrister, er, and he said 'P, you've got a stiff neck'. I said, 'No I haven't I'm absolutely fine' and he said, 'P, you've got_a stiff neck'. I said, 'I don't want the money I just want to be fit and to move and I am alright.'

Dr E's (A&E) experience of having a whiplash injury was different from Dr A's, as he continues to experience problems related to his neck and he is wary of attributing his problem to the whiplash injury. He also points out that he managed to work with his injury. This might seem to suggest that he thinks other people should also be able to carry on working but in retrospect he feels shouldn't have continued working:

Dr E: In my experience, I have had my whiplash myself [Frances right] and I worked when I had the whiplash and to be honest, still now, when I'm sitting doing things, I start spasming of my neck. So I don't know if that is connected or not. Definitely, I wasn't like that before the whiplash.

Frances: When was your whiplash injury then?

Dr E: It was, er, 2000 I would say 2000.

Frances: That's 4 years ago and you've kinda got some residual.

Dr E: Yeah yeah

Frances: Neck pain?

Dr E: Still I do. If I'm computering or studying something. I mean [p], er, 15, 20 minutes and I have to stop. My neck, er, and the same exact feeling of the whiplash but the difference is that after relaxing that will, [the pain] goes off but with whiplash it stays for, it will stay for constantly.

Frances: Right. So the acute's constantly painful, but...?

Dr E: Yeah. But the chronic it's on and off, er, depending on the position of the neck.

Dr E draws on his own experience when giving advice on managing patients' symptoms. The advice he gives to patients differs from the advice given by his colleagues as it also includes the things that he found helpful:

On the top of that it's massage or warm shower, warm bottles, patients find that quite helpful as that decreases the

spasm of the muscle by increasing the vascularity to the muscle supply so...that's what patients find quite helpful.

This demonstrates how personal experience can be helpful in understanding what it is like to have a particular condition and therefore be more sympathetic towards someone else in a similar position. It is important to take care not to assume that one's own experience is going to be exactly the same as another person's experience. This is important as both Dr A and Dr E who, because of their position as middle class professional males, were able to continue working with their whiplash injury, might expect other people to be able to continue with work. .

Chapter Nine Intregation and Discussion

In the preceding chapters I have detailed the thematic findings that have identified how multiple meanings can be held by both doctors and patients regarding the phenomenon of whiplash injury. The phenomenological approach to inquiry seeks a deeper understanding of phenomena through analysing accounts of human experience to yield richer and deeper descriptions (Van Manen, 1990). It seeks to understand the meaning of the phenomenon by asking those who have experienced it to describe their experience (Van Manen, 1990:9). Interpretative phenomenological research recognises that there is always more than one interpretation of a particular experience. The phenomenologist, Toombs (1992) suggests that with the experience of illness there is a specific reason for the differences in meanings to be ascribed to the same medical condition by doctors and patients. This is because doctors and patients are seen as inhabiting different worlds and this is specifically related to the different ways that doctors and patients understand the experience of disease (Toombs, 1992:xv). From my research, these differences arise out of the doctor's conceptualisation of whiplash injury, one that is based on the biomedical system of disease classification. In chapter two it was shown how this system identified whiplash injury as a simple muscle sprain and in common with any other muscle sprain, the symptoms are expected to resolve fairly quickly. This contrasts with the patients' emphasis on their experience of symptoms of pain and disrupted movement and what that might mean for their everyday lives.

The intention of this study was to examine the meaning of the experience of whiplash injury from the patient's point of view alongside the doctor's point of view to see if

this might have implications for how whiplash injury is understood and responded to in healthcare provision.

The different perspectives can be seen in chapters five, six and eight. In chapters five and six, I have shown the different meanings and experiences that can arise with a whiplash injury from the patient's perspective. In chapter five, case studies were used to present the individual accounts of their experience. In chapter six, I detailed the overarching themes of *healthcare experience*, *embodiment*, *making sense*, *patient expert* and *whiplash: a minor injury?* Chapter eight shows the doctor perspective and details the themes *expectations re what a patient will experience*, *what patients do about their whiplash* and *what doctors do*.

In this chapter, I integrate both the doctor and patient accounts, which involved a further analysis. I begin by specifically drawing on the doctor and patient accounts to elucidate the psycho-social experience of whiplash injury, the different approaches that appear to be taken towards whiplash injury by the doctors and will end with the emergence of the issue of trust for the doctor-patient relationship.

9. 1 The Psycho-social experience of whiplash injury

From the patients' accounts in chapters five and six, it is quite clear that they all found whiplash to be an intrusive and incapacitating injury that required them to make lifestyle adjustments to be able to manage it. However, the length of time that each participant needed to make adaptations to accommodate their injury, varied from as little as three weeks to eighteen months and longer. The extent to which the participants experienced whiplash injury as an intrusive condition came from both the

way the symptoms were experienced and the extent to which they were seen as undermining their ability to carry on as normal. The changes that participants experienced came from both the trauma associated with the accident and the whiplash injury itself. The effects of the changes were felt on their bodies, daily activities and relationships. The participants also found it difficult to make sense of their actual experience of a whiplash injury and reconcile it with the medical view of whiplash. Furthermore, the experience of learning how to make sense of, and accommodate, their injury in a way that enabled them to continue leading a 'normal' life, led them to become 'experts' on whiplash injury.

9.1.1 The malfunctioning body

The doctors in this study had very little to say about the physical or emotional problems that patients might experience with whiplash injury. This might be because they do not know the types of problems that their patients might have with this injury or it might be that the problems are not considered to be serious enough and therefore these are judged to be unimportant or not the business of doctors. From the patient participants' accounts it is quite clear that there is usually a delay between sustaining the whiplash and the participants feeling that something was not quite right; they felt different about themselves. Following the car accident, the participants' response was to check that they had not been injured. In doing this, their bodies became an object that needed to be examined for obvious signs that might suggest they had been injured in some way. None of the participants showed any immediate concrete signs such as cuts or swellings that might be taken to indicate that they had hurt themselves, although some participants felt themselves to be different. The subtleties of the changes that were taking place within the body at that time were often not visible to

the naked eye; they would only be detected at a physiological level (Damasio, 1994). The changes that were perceived by the body would be concerned with what could best be described as preverbal bodily communication. By this, I mean the communication that would take place between the physiological receptors and the brain that is reflected in sensorimotor experiences. These experiences arise from the early development of motor movement activities required for body posture and bodily actions such as walking, that precede the development of language. Wider (1997:149) argued ‘that the most fundamental level of self-consciousness is the body’s awareness of itself in sensorimotor activity’. It was the changes in their sensorimotor experience that led participants to feel or sense that something was different, that something was wrong with them. Corbin (2003:258) suggests that people come to know their own bodies and understand ‘its needs and language’. This understanding of one’s own body is constant and does not change even though there are times in life when the body undergoes many changes; for example, adolescence and old age. Corbin (2003:258) states that:

...there is still a sense of ‘knowing one’s body’. For example, persons know how their body reacts to stress, how much they can do before becoming fatigued, what happens when they eat too much and play too hard.

This is important, as to know one’s body suggests that people will also know when their body is different or not right.

As discussed earlier in chapter six, an important aspect of the body functioning ‘normally’ is that it is taken-for-granted. That is, the body is not the focus of attention and forms the background to one’s attention. Being able to take the body for granted is important as this allows the body to form the background to a myriad of activities

and projects that are carried out. For example, I automatically turn my head as I look behind me to see who has walked into the room whilst I am sitting down working at the computer. I do not have to think about how I have to carry out this action, I just do it. The loss of the taken-for-grantedness of the body occurs during illness as the body becomes the focus of attention. The body's appearance to consciousness arises from the dysfunction caused by the illness (Frank, 1998; Leder, 1990). During illness the changes that take place within the body lead to what can be understood as 'unhomelike being-in-the world' (Svenaesus, 2000).

Svenaesus (2000: 125) built on the work of Heidegger to develop a phenomenology of illness with particular reference to the phenomenon of '*Unheimlichkeit (meaning unhomelikeness)*'. For Heidegger (1927) to become a human being means to be born to unheimlichkeit, that is, to homelessness. The a-priori homelessness of human existence is explained as 'unhomelike-being-in-the-world'. Heidegger saw that the being-at-home of human being-there (Dasein) is always also a not-being-quite-at-home in this world. There is a difference between a constant sense of 'obtrusive unhomelikeness' and the more normal background sense where there is a kind of duality of being-at-home-in-the-world and not-at-home-in-the-world. Any person will, at some level, experience a sense that they aren't quite at-home-in-the-world. But what can happen in illness is, when it disrupts things, it comes absolutely to the fore.

Svenaesus used Heidegger's phenomenology of being-in-the-world to reveal how illness is experienced by humans as not-being-at-home in my world. Being ill, then, means that a 'constant sense of obtrusive unhomelikeness in one's being-in-the-

world' is experienced (Svenaesus, 2000: 131). During illness the body is experienced as 'alien', as a 'broken tool' that both changes and obstructs the way we feel and the things that we can do, thereby producing this state of 'unhomelikeness'. Whilst this state of 'unhomelikeness' might be more apparent in the immediate and potentially catastrophic changes that a person might experience as a result of a cardiovascular incident such as a stroke, it is also experienced in less obvious conditions such as diabetes. The immediate apparentness of the broken body arises from the visible distortion and loss of bodily functions; for example, changes in facial features, loss of or distortion to speech and bodily movements. The notion of 'unhomelikeness' provides us with a way to understand how the changes that take place within the body following a whiplash injury, lead to the perception that one's body is different, that something is not quite right. This 'unhomelikeness' is the malfunctioning body.

The participants' awareness that their body was in some way different to 'normal', that is, it was 'unhomelike', arose out of two distinct, but often interrelated, effects of whiplash injury. The first was through the participants feeling some degree of pain in the affected areas. The second comes from the way that changes in bodily postures and movements were experienced by the participants. Often this was related to a range of movements that involved the neck or spine. For example, the simple action of turning one's head might be difficult as the muscles in the neck had stiffened. It was more common for the participants to experience both effects rather than just one of the effects.

It is well recognised that pain is a personal experience imbued with meaning that, according to Bendelow and Williams (1995), owes as much, if not more, to the

emotional and cultural influences that shape everyday lived experience, as it does to physical sensation. The significance that is attached to the experience of pain plays a part in determining how it is both understood and managed by the individual (Osborn, 2002; Turk, 1996). Williams and Thorn (1989) suggest that the formation of pain beliefs might be a major element in the perception of pain and their work also suggests that personal beliefs about conditions might be discordant with scientific understanding. For example, the strength of pain that is felt by an individual is often taken as an indicator that there must be something seriously medically wrong with them to account for their experience. As we saw in chapter six, the participants described the pain they experienced as being severe and that this led them to think that their injury was more serious than they had at first thought. This finding is similar to what Osborn (2002) found in his study on women who suffered with chronic pain. The women in his study remained convinced that there must be something medically wrong with them to explain their condition. Managing the pain from whiplash injury appeared to be unduly problematic for the participants for various reasons, such as a reluctance to take pain relief or its ineffectiveness if taken. The poor management of pain meant that the participants in this study remained aware of their body through the presence of pain. The presence of pain also interfered with some participants' ability to sleep. The pain, rather than the difficulties experienced in body posture and movements, was seen as the reason for problems with sleeping. The simple process of going to sleep without waking up throughout the night was no longer achievable and a period of sleep deprivation that could last as little as a few days or persist for several months was experienced by the participants. The lack of sleep was often used by the participants to understand why they had become irritable and had problems concentrating. The cognitive effects of irritability, fatigue and poor concentration that

are associated with whiplash injury (Sterling et al., 2003) are also found in sleep deprivation. This effect was very noticeable to the participants as it meant they had less patience and this appeared to create a barrier in their relationships.

The combination of experiencing pain and changes in bodily movements meant that a participant's body became an object that was under constant (self) monitoring as they had become unsure of movements that they had previously been able to carry out unthinkingly. Whiplash injury also focused the participants' attention on the physical activities that had previously been taken for granted and challenged their previously held ideas of what they were able to achieve. The challenging of previously held beliefs is similar to that which is experienced by people with a chronic disabling illness in which the disruption to the automatic tasks that include dressing and walking become central to the self concept (Leventhal et al., 1999).

For the participants in this study, the uncertainty that was produced from the experience of symptoms from whiplash injury appears to be different to the uncertainty experienced with other musculoskeletal conditions that affect the body, such as low back problems and arthritis, for two reasons. First, the focus on the body by the individual with lower back problems or arthritis appears to be intermittent in nature, reflecting the ebb and flow of the symptoms that the individual experienced (Weiner, 1975). This contrasts with the constant awareness of symptoms from whiplash injury. Second, the uncertainty for the individual with arthritis only appeared after a diagnosis was given. Bury (1988) found that the symptoms of arthritis that were experienced by participants in his study, were not seen as having any particular significance until the diagnosis of rheumatoid arthritis was given. Mrs

M, one of the participants, on being given a diagnosis of rheumatoid arthritis, changed the way she regarded her symptoms. The symptoms she experienced had become an indicator of her malfunctioning body that needed to be attended to and this also raised the issue of what this might mean for what she would be able to do in the future. For the participants in the present study, the experience of the symptoms was enough to create and maintain a state of unease.

The participants in this study continued to regard their malfunctioning body as 'me' even though their body had become an object, in the sense of being under scrutiny. This is different from the way the participants in Osborn and Smith's (1998) study on chronic pain saw their bodily malfunction. They saw the part of themselves that suffered from pain, as being an alien self that needed to be disowned. Morse and Mincham (1998:669) found that patients with severe burns distanced themselves from their body during the most painful parts of their stay in hospital. One participant who had been electrocuted referred to his right hand by saying 'my hand right hand was up high' but after he was electrocuted his badly burned right hand became an 'it' and it [his right hand] had to be removed. They also found that once the patients with severe burns began to recover, they reclaimed their bodily parts. Finlay (2003:163) also reports on how, 'Ann comes to see her arm as an 'it,' something apart from herself, something out of control.' This was within three months of being given the diagnosis of Multiple Sclerosis. Ann had stopped experiencing the wholeness of her body as she no longer considered her arm as 'part of me'.

This contrasts with the participants' experiences in this study. One possible explanation that might account for the participants' experience of the malfunctioning

body from whiplash remaining firmly embodied along with a personal sense of 'I', that is 'me', may be due to the anatomical location of the head and neck at the top of the spine. The skull and spine form the structure that brings together the other parts of the body to form a whole. In that sense, the arms and legs can be understood as attachments to the body that can be disconnected or disembodied in a literal sense through amputation and replaced with prostheses. This clearly is not the case with the head and neck. In addition, developments in scientific knowledge have led Western cultures to consider the head as the centre of consciousness (Velmans, 2000), whereas other cultures (also) use parts of the body other than the head to give meaning to experience. An interesting example of this is Hinton et al. (2001) talking about the neck and what that means for the Khmer culture. In Khmer culture the neck was identified as the area of the body that played a central role in the presentation of distress and any difficulties that were experienced in the neck were understood by the Khmer to signify the possibility of death.

The participants also felt the impact of the changes in their daily lives as they found themselves unable to perform a range of hitherto taken for granted activities that were related to their roles in society. They found that in order to manage their situation they were forced to withdraw from their normal ways of being and wait for the symptoms of whiplash injury to subside or develop new ways of accommodating the symptoms that enabled them to carry on with their life. The participants could no longer unthinkingly go about their daily activities such as work, or take part in a particular sport or hobby.

9.1.2 Changing identity and changing roles

It is well recognised that both serious acute and chronic illness can have consequences for the ill person's identity and affect their social roles and relationships both at home and at work. An example of this would be the person who is no longer able to carry out their usual occupation. This would involve a loss of their usual occupational role and either a temporary or permanent loss of their role as a wage earner (Charmaz, 1991; Anderson and Bury, 1988; Ruberman et al., 1984). As noted earlier, chronic illness represents a biographical disruption to the life story (Bury, 1982). Less obvious but just as important are the changes that take place within the family; for example, when any carer is unable to carry out the physical demands that can accompany the care of small children or even carry out household tasks like cleaning and cooking.

One limitation of the literature comes from the lack of research on the social consequences of 'minor injuries' or musculoskeletal conditions in general. One study by Strunin and Boden (2003) looked at the family consequences of low back injury and found that a wide range of limitations on family and social roles were experienced by the respondents. These included the ability to undertake household tasks, looking after children and engaging in leisure activities with spouses.

In my research, the whiplash injury was shown to have social consequences that had an immediate affect on the participants' everyday roles and relationships in their home, work and social lives. These consequences arose out of the physical limitations brought about by the whiplash injury which, like arthritis, affected everyday activities due to the difficulties experienced with movement (Bury, 1988). This research also showed how the practical support that was given to the participants by their family,

friends and work colleagues helped to moderate the problems they experienced during the acute phase of the injury and beyond, into an unknown timescale or trajectory that arises with a chronic condition. The idea that there is a trajectory that might help to account for the changes that individuals experience between 'acute conditions' being recognised as 'chronic conditions', is a recent development in understanding the experience of illness (Crossley, 1998; Paterson, 2001; Whitehead, 2006). The notion of trajectory is important for health care professionals as it can help them to understand what it means for people to live through different stages of a chronic illness and why they might choose to use coping strategies that might appear to be unhelpful from a professional perspective (Paterson, 2001). There does not appear to be anything about trajectories in whiplash injury, however there are similar studies in other related areas but they apply less well to whiplash injury.

Whitehead (2006) looked at the reconstruction of self-identity with patients who had Chronic Fatigue Syndrome. This process was identified as having a trajectory that comprised of three phases. The 'acute' phase was described as the time when patients found they were completely debilitated and they took on the traditional sick role. The medium term phase was when there was an awareness of limitations on the self. The longer term phase for the majority of participants was defined as the positive reconstruction of self. This was also related to the development of coping strategies. Whitehead also highlights the dynamic quality of the trajectory and that these phases might have implications for healthcare professionals.

The present research lends support to the idea of a trajectory and this concept can be usefully applied to understand some of the changes that were experienced by the

patient participants on their roles and relationships following an experience of whiplash injury and the potential consequences for their identity. During the acute phase, all the participants in this study experienced changes with their family roles through the limitations placed on their usual activities. Whilst some of these changes were of short duration and posed minimal disruption to family life, there was the potential to threaten the very fabric of family life and turn it upside down as new dependencies were created. This finding is similar to that found in studies where workers are considered to have a long term musculoskeletal problem that prevents them from working (Morse et al., 1998; Strunin and Boden, 2003).

With the exception of Margaret, the participants in this study said that their whiplash injury had not affected their relationships with their partners. This contrasted with Strunin and Boden's (2003) finding where the respondents with low back injury reported that the physical aspect of their relationship with their partners had changed as a consequence of their injury. My participants did not talk about sex or even intimacy very much during their interviews. There are several reasons why this situation arose in this research. The first is the interview technique. Strunin and Boden's interviews were carried out by telephone, this may have made it easier for the respondents to talk about more intimate aspects of their relationship with the interviewer; for example, the sexual side of their relationship. In contrast my interviews were face to face, so that the expression of any changes that were experienced by the participants in their ongoing relationships with their partners meant they were possibly less likely to be revealed. Also as a female interviewer the male participants may be less likely to disclose details of an intimate nature and I did not specifically ask questions about the physical side of their relationship. Research

into sensitive topics has also suggested that the participant is less likely to disclose when a study requires them to take part in more than one interview (Lee, 1993; Brannen, 1988). The participants with children said that the whiplash injury had more effect on the relationship with their children than with their partners. This change seemed to be more noticeable with young children than it was with older children. See for example Bill's account of the changes in the way this affected their play, in chapter five. Martin also had young children but they were of an age where they could understand that 'daddy was ill'. Unhomelikeness is demonstrated in the sudden impact of not being able to play with your children. It might also be easier to admit that there is a change in the parent-child relationship rather than the loss of intimacy with their partner. The loss of togetherness experienced during play is immediate and it can be difficult for young children to understand why 'daddy was different'. Studies that have looked at the impact of cancer on family relationships show that having a family member with cancer brought about a different way of being in the family and that this could be experienced as loss (Woodgate, 2006). The whiplash injury led to a loss of a particular way of being for the child and their parent. These findings are in line with Ying-hwa Su and Ryan-Wenger's (2007) study that looked at children's adjustment to parental cancer. They found that the relationship between child and parent was affected by the changes in the parent-child interaction. They also found that the age of the child was an important factor in the adjustments that were made between the child and the ill parent.

The doctors made little reference to the possibility of this injury causing any specific problems with work, unless the type of work was seen as being physically demanding. However, all the participants experienced limitations with their work activities

because of their restriction in movement. Although those with more physical jobs were clearly more impaired, all the participants, even those in sedentary work, faced some restrictions. The case of Margaret in chapter six was a particularly good illustration of this where a new sickness policy had been introduced. She was able to go into work despite the policy, only because of the active support of her colleagues.

This study suggested that people's relationships at work play an important role in enabling them to accommodate minor conditions that are not considered to have any special need for support. Moreover it draws attention to the informal practical support that is given in the workplace. The value of the practical support given by colleagues can also be seen through its moderating role on the economic difficulties that would otherwise occur through the loss of earnings (Morse et al., 1998; Strunin and Boden, 2003).

9.1.3 The context of a motor vehicle accident

In chapter two it was seen that it is widely accepted that motor vehicle accidents are a major cause of psychological trauma throughout the western world (Blanchard and Hickling, 1997) that can lead to the development of post traumatic stress disorder or travel anxiety (Mayou and Bryant, 1994). More recent work by Mayou and Bryant (2002) suggests that the long term impact of psychological trauma following motor vehicle accidents has been greatly underestimated and, more importantly, that little is known about psychological responses that occur in motor vehicle accident victims who have had a minor injury.

From the participants' accounts in this study it can be seen that they found their accident to be a source of anxiety and distress. Their distress at being involved in a motor vehicle accident was revealed when they were asked two simple questions: how they felt about the accident and whether their driving had changed in any way. All the participants reported that they experienced the accident and whiplash injury as a source of anxiety and distress. Unhomelikeness can also provide a way of understanding the anxiety experienced by all the participants as they came face to face with the frailty of the human condition that ultimately results in death. The distress the participants experienced was as much to do with the practicalities of making an insurance claim or the inconvenience of getting their car repaired as it was to do with the effect of their injury. The participants also experienced anxiety when they were travelling by car at the time of the first interview, whilst three of the participants continued to feel anxious in the car twelve months later. This suggests the possibility of the coexistence of a psychological injury alongside the whiplash injury. This might help to explain why some patients might go on to experience whiplash injury as a chronic condition and be a possible area for further investigation. If you are anxious and tense your muscles will also be tense. This idea is supported by Kongsted et al. (2008) who looked at stress and recovery after whiplash injury. They found an association between an acute stress response which means to suffer from anxiety, intrusive thoughts, avoidance, and chronic whiplash and suggest that it is important to consider this in the early management of whiplash injury.

The findings of this study are similar to recent work undertaken by Smith et al. (2007) that looked at the psychological needs of people who had sustained minor injuries in a motor vehicle accident. They identified clinically significant levels of anxiety, post

traumatic stress disorder and depression and suggest that these might interfere with the participants' daily lives. These were seen as having the potential to affect career prospects if significant amounts of travel were involved, social activities if maintaining contact involved travel and relationship difficulties if they became dependent on their partner to drive or would only use specific forms of transport. They also raised the issue of the importance of clinicians in Primary and Secondary Care recognising, assessing and treating psychological distress in people who have had a minor injury following a motor vehicle accident.

9.2 Doctors' approaches to whiplash injury

Having examined the psycho-social experience of whiplash injury, it becomes evident that the doctors who took part in this study are not fully aware of what having a whiplash injury means for their patients. This situation can be attributed to biomedicine's focus on objective criteria as a means of explaining a patient's physical experience of symptoms from whiplash injury. Toombs (1992) and McWhinney (2001) have suggested that taking an approach that has its focus on lived experience will assist doctors and others to understand more fully what any particular illness means both for the individual and for medical practice. Having established that there are differences between the two perspectives of doctor and patient, it is reasonable to suggest that there might also be differences between doctors' approaches and patients' experience of the doctor's approach towards whiplash injury.

I began to get a feeling that there was something about some different behaviours embedded here and I felt the need to revisit the doctors' data to have a look at this

more closely. The doctors' descriptions of their behaviours called out to me and I found myself reflecting upon my own reaction to these. For example, when the doctors were being dismissive, I felt like my concerns were brushed aside and when they were being proactive I felt that was good as they were anticipating what might happen. Three behavioural approaches were identified through analysis and I am going to call these 'dismissive', which means to brush off or set aside patients' concerns about their symptoms; 'reactive', which means to take patients' concerns seriously and respond to symptoms as they arise and 'proactive' which means to take patients' concerns seriously and anticipate the possibility that their symptoms might become problematic. In this section, I am going to describe the steps that led me to make this interpretation.

When I became aware of the possibility that there might be differences between the doctors in their responses towards whiplash injury, I re-analysed the doctors' data, returned to the patients' data set and looked for examples of what I thought might be perceived as that response by a patient. There was a problem in looking for examples of these approaches in the patients' interviews as I had not specifically asked a question about their doctor's approach and so would find potentially few examples. I had asked the patient participants what they thought about their experience of their treatment and so re-examined this data with these approaches in mind.

9.2.1 Dismissive approach

In this approach, the injury was not seen as serious and no significance appeared to be attached to the symptoms that the patient might be experiencing at the time of the consultation. The injury was understood as a simple sprain of muscles in the neck.

The possibility that the patient might experience deterioration of their symptoms and that it could become a chronic condition did not appear to be considered. Here are some examples of what I considered as the doctor being dismissive:

If you examine them properly and find out their neck is ok it's just a whiplash [which] could even be advised at the GP reception.

Dr D (A&E).

I think if I was to ask them to come back for a follow up that might perpetuate the idea of it.

Dr B (GP).

Here are some examples of what I took to be a dismissive approach in the patient participants' accounts:

Frances: So did you think it was quite helpful the information you were given?

Linda: Erm, the information was helpful, yeah.

Frances: You don't sound too sure about it.

Linda: It was like it was somat and nothing because it's been giving me a lot of pain it was treated I think like it was somat and nowt like an everyday occurrence and you just have to go away and get on with it. But that's all.

Frances: That's all.

Linda: Mm

Frances: Just that it was like an everyday occurrence.

Linda: I think yeah it wasn't, because I was so shocked from the accident as well and upset and everything. It was probably treated like if you'd cut your finger or something.

Linda also did not feel reassured:

Frances: So then how do you think you should have been treated, have you got any ideas?

Linda: [p], erm, I don't know maybe, erm, maybe an x-ray. I don't know. Just to see if there were any damage or, erm, I don't know.

Frances: Did you feel there might be more damage than when you went to see them?

Linda: er, [p] I don't know, just that because I've had trouble with the bottom of my back as well as my neck, I just wondered if there was more damage done than they thought there was.

Bill also described his experience with the first doctor that he saw as:

‘It’s just whiplash go away take paracetamol’.

This interpretation of whiplash appeared to be taken by two A&E doctors and one GP. One reason for this may lie in the fact that the doctors who worked in the A&E department were more likely to see patients soon after the accident when it is unlikely that the full effect of symptoms from whiplash will be evident. The doctors in the A&E department would also treat life threatening conditions and by comparison whiplash would be seen as ‘just a minor condition’. This would not necessarily explain the GP’s interpretation of whiplash injury as the GP would spend a substantial amount of time seeing patients with minor illnesses. One doctor who also worked in A&E did not take this approach towards patients with whiplash injury. This suggests that there is something more than the place of work influencing the doctor’s approach.

In chapter one it was noted that the types of diagnostic skills that doctors use to diagnose patients problems could vary according to the severity of the problem, the frequency and the level of their professional expertise. More experienced doctors often used a process of pattern recognition and that this process is “strongly effected by context” (Elstein and Schwarz, 2002: 730). The tendency to jump to predetermined criteria is in line with a common observation that they used pattern recognition rather than a full hypothetico deductive process and this might mean that the doctors who took this response were less critical than the other doctors in this sample. It is possible that the doctors who were dismissive might take a more traditional authoritarian style towards patients and take an ‘I know best’ attitude. Alternatively

this might reflect a desire to minimise patient dependency and reinforce patients' responsibility in managing their own problems (Salmon et al., 2007).

9.2.2 Reactive approach

This approach differed from the dismissive approach, as some significance was attached to the symptoms the patient might experience at the time of the consultation. The injury was still seen as not being serious and understood as a simple sprain of muscles in the neck, but it was recognised that the symptoms might be a little problematic for the patient. It was also recognised that symptoms of pain might be problematic to treat and that the whiplash might develop into a chronic condition. This approach might also indicate a style of communication that leans towards being patient-centred. This might also indicate that the doctor is more sympathetic towards patients with whiplash injury or is able to be more empathic. Empathy means to be able to enter into the patient's world as if it was their own (Mearns and Thorne, 1999).

Here are some examples of what I considered as the doctor being reactive:

...if someone has persistent problems and [p] and it's not settling down and we've encouraged them to try and use their neck normally and we've given them treatment and they are still increasingly distressed with their neck, my next port of call would be to physiotherapy to try and get the neck pain settled through physiotherapy. (Dr G/ GP.)

I see them the once and say if they're having any trouble still, to come back because, er, there's a variable amount of time that they'd want off work or they need to have off work.

Frances: So you say to them you can come back?

Dr H: Yeah.

(Dr H/GP).

Here is an example of what I took to be a reactive approach in the patient participants' accounts:

Martin's doctor suggested to him that it was a possibility that he may have to see a physiotherapist if it did not settle down as expected:

Martin: He didn't recommend, well he said try, no he didn't actually recommend that I go to a physio'.

Frances: Just to try this?

Martin: Just to try this, them exercises because it'll make it a lot easier for a physio', because you've done half of the physio' already for them.

I interpreted this as Martin's doctor being aware of the possibility that there might be extended problems, but that he would respond if and when Martin had extended problems. The idea of 'wait and see' also seems to make it easier for Martin to return to his GP: *'I went back on the Monday' (Martin).*

In this example, Rav considers returning to his GP for further advice:

I'm thinking of going back to the GP and asking him, erm, if there is any other way I can speed up recovery or anything like that.

Wendy showed how Bill's experience of his GP's approach contrasted with the first doctor he saw:

Yeah at least he showed some concern and it wasn't just like at the hospital where it's just whiplash, go away - take paracetamol. And you got appointments when you needed them as well.

Here is an example of how Steph's doctor reacted and responded to her concerns:

When I saw her I told her we'd been in an accident and I said that I just ached all the time and I felt like I ought to get checked over. I was getting headaches and flashbacks and I just felt really, really down on the Monday. And she actually gave me some diazepam to try and calm me down and to help me sleep. Erm, she checked me over.

9.2.3 Proactive approach

In this approach, the injury was seen as not being serious but some significance was attached to the symptoms that the patient might be experiencing at the time of the consultation. It was also preventative. The injury was understood as a simple sprain of muscles in the neck but it was anticipated that the symptoms, in particular the symptom of pain, could become problematic for the patient before the whiplash settled down, or the whiplash might go on to become a chronic condition. This approach might also mean that the doctors' style, whilst strongly patient-centred, is also more focused on doing something about it.

This is an example of what I interpreted as the doctor being proactive:

*I tend to make plans ahead saying on the basis of how you are now, maybe you'll just want to take some paracetamol. But if you're worse tomorrow you're going to want some other things, so here's some codeine and here's some anti-inflammatories and if you're still not able to move then I want to see you again.
(Dr A/ GP & lecturer).*

None of the patients suggested this approach.

Turning to the literature, I found support for the idea that doctors could take a dismissive response towards patients' concerns (Wissow et al., 2005) but not the other two patterns. I was encouraged by this to continue with and develop this idea.

One reason for the three different approaches may well be due to the different definitions of whiplash injury and accompanying symptoms that are used within healthcare provision (see chapter one for full discussion). For example, if the whiplash injury is understood as a simple muscular sprain of the neck, it might be

viewed as nothing to worry about as muscular sprains in other parts of the body usually resolve in a few weeks (Pearce, 1999). As suggested in the previous section, the fact that the diagnosis of whiplash has several competing definitions was an important consideration as the diagnostic criteria are used by the doctor and healthcare provision to inform decisions about actions taken to manage the condition.

Another reason for the difference might be due to the differences in the way the doctor sees their relationship with the patient. This relationship is often described as being either doctor-centred in which the disease or illness is the focus of the interaction or patient-centred (Dulmen, 2002). Stewart et al. (1995) identified six aspects to the patient-centred approach. These are: exploring both the disease and illness experience, understanding the whole person, finding the common ground regarding management, incorporating prevention and health promotion, enhancing the doctor-patient relationship and being realistic about personal issues such as the availability of time and resources. The doctor-centred style is associated with a doctor who emphasises the use of knowledge and skill in dealing with patients' complaints as opposed to listening to patients' accounts (Marks et al., 2005). As with any relationship, communication is seen as being key aspect of the interaction that takes place between doctor and patient and, like the relationship, the style of communication is defined as doctor-centred or patient-centred. The doctor's communication style has been implicated in the way patients might perceive and respond to the care that might be provided (Lewin et al., 2009). The doctor who sees his relationship as doctor-centred would be dismissive because he would use his own knowledge and focus on the particular problem. Therefore, the doctor who is patient-centred could be reactive as he would be listening and responding to the patient's

account, or be proactive by trying to prevent problems arising. The correct thing to say is that I just don't know why there are differences. It might be that some people habitually take one line but I'm not arguing that it is intrinsically a personality dimension. Even if these ways of organising the data are just that, there are patterns that one could recognise and understand as a behavioural response.

9.3 Implications of approaches for the patients' experience

I will now go on to look at the three approaches that I have identified as being taken towards a presentation of whiplash and discuss how each of these approaches might have different implications for the patients' experience of whiplash.

9.3.1 Dismissive approach

The dismissive approach taken by the doctors to their own patient's presentation was to confirm that they had had a whiplash injury, that it was not serious and that it would settle down. The general expectation in this case was that the injury would be concordant with the medical model and that it would resolve. The participants who experienced their doctor's approach as dismissive said it was because their concerns had not been taken seriously and they were not reassured by the doctor's comments that everything would be alright. This study (see chapter six) showed that the reasons given by the participants for seeing the doctor, were linked to the bodily symptoms that they began to experience from their injury. The patient might complain of pain or complain they are experiencing difficulties with movements that involve their neck even though the actual physical changes that might have occurred to the body from the whiplash are not obvious when the patient is examined by the doctor. From the

literature reviewed in chapter two, it was shown that it could be several days before the full effect of symptoms from whiplash injury on body movement and posture can be seen (Teasell and Shapiro, 2002). This raised the issue of what might happen to the patient who finds themselves in this situation if their injury remains troublesome. Who do they go and see and how do they manage their condition? It is also possible that a patient who returns to see their doctor at a later date might have their condition redefined and labelled as something else, such as chronic pain. This means that it might be understood as a medically unexplained condition which can also invoke a dismissive response.

Another possibility that might help to explain this approach comes from the perception that the injury offers the patient an opportunity to seek compensation. I will be returning to this in section 9.3. This means that the patient is required to have their injury documented to validate the claim. As noted earlier this was raised as being a particular problem for the A&E department. This raises the possibility that the doctor might not trust the patient's primary reason for wanting to be seen.

This research is supportive of the recent literature that gives recognition to a growing awareness that doctors can be dismissive towards patients who are concerned about physical symptoms or those patients who demand some form of emotional support (Salmon et al., 1999; Wissow et al., 2005). Salmon et al. (2007) looked at general practitioners' responses to patients who presented with medically unexplained symptoms. They found that doctors were more likely to be dismissive or critical of their patients when they regarded the demands of the patient as excessive or illegitimate. An illegitimate demand might be related to the patient seeking

compensation and the requirement to undergo a medical examination before a claim can proceed. Dr B holds the perception that patients present with a whiplash injury as a preamble to claiming compensation. This contrasts with his GP colleagues who were aware of this possibility but felt that in the majority of cases this was not the case. Salmon et al. (2007) suggested that being dismissive might reflect an attempt by the doctor to minimize dependence and emphasise the patient's responsibility in managing their problems. They also suggested that understanding the doctors' responses towards patients may allow more effective interventions to improve the quality of consultations.

9.3.2 Reactive approach

The approach of the doctors to the patient's presentation in this account was to confirm that they had a whiplash injury, that it was not serious and that it should settle down. The potential of the pain to become problematic was held in mind and a reactive stance to treating the patient's symptoms would be taken. The doctors who took this approach were more likely to want to access treatments such as physiotherapy for treating the pain and diminished movement. This approach might be understood as the doctor being able to tolerate the ambiguity that can be produced with symptoms from whiplash injury and the challenge of managing it. The effect of this approach meant that their patient might also be more likely to return for further advice if they continued experiencing difficulties from their whiplash injury. Whilst it is important to state that all the participants could return to see their doctor, as indeed some of them did, the patients who experienced this approach felt more able than others to exercise that choice and return with their ongoing concerns. Turning to the participants in this study, it can be seen in Martin's account in chapter six that he felt

able to choose to return and see his doctor on several occasions when the injury continued to be problematic. As noted earlier this contrasts with Hazel's reluctance to go back as she had been told nothing could be done for it.

9.3.3 Proactive approach

The proactive approach indicated a preventative approach to managing the symptom of pain. With this approach the patients' presentation of their symptoms is not under question, even though it might not be a typical presentation. The doctor trusts the patient's account. The response of the doctor in treating the condition is not dependent on the patient's presentation of symptoms. The diagnosis is sufficient in itself as the doctor is able to anticipate that the symptoms will more than likely become problematic. The approach of the doctors in this account to the patient's presentation was to confirm that they had a whiplash, which was not serious but they might find their injury could become quite painful. This approach also emphasised that it was important to manage the symptom of pain otherwise it might create further difficulties for the patient. This was because the pain was seen to inhibit the patient's normal range of movement and activities. Sometimes people get the impression that the patient-centred method is about being sympathetic but it is actually about trying to understand things and respond to things as experienced by the patient. In this condition, that means being willing to use treatment perhaps quite aggressively where appropriate.

From the patients' accounts in this study, the proactive approach to managing whiplash was not evident i.e. no patient mentioned, their doctor focusing on their pain or informing them that the pain would more than likely get worse before it started to

improve. It seems fair to say that the patient who is treated in this way might be more prepared to take treatment aimed at managing the pain. This response is an important one as there is a growing body of evidence that suggests patients who feel listened to and are given good information about the value of interventions, are more likely to carry out the doctor's request (Moore et al., 2004; Hagihara and Tarumi, 2009). Another reason why this approach is not evident from these accounts might be related to the patients who chose not to take part in this study. It is possible that patients who have experienced this approach were happy with their treatment and thought that they had nothing to contribute to this study. Alternatively this approach may simply be uncommon. This might be a fruitful area for further research to see if this approach might be beneficial by reducing the likelihood of this injury becoming a chronic condition.

O'Flynn and Britten (2006) looked at Primary Care practitioners' approaches to the management of menstrual disorders and the idea of shared decision making. They identified two approaches that the practitioners took as being either a biomedical approach or a patient-oriented approach. The biomedical approach meant a focus on the biomedical model of disease, skills learnt during medical training and the concepts of diagnosis, disease and cure. The patient-oriented approach meant that the patient was seen as a person. This meant that individual patient's agendas and needs were explored. However taking a patient-oriented approach did not always mean this, as many of the practitioners were guided by their own assumptions rather than a discussion that would identify what individual patients might want. O'Flynn and Britten also raised the issue of the doctors' professional identity and that the use of the biomedical model is a means to maintain their identity as doctors. The reactive and

proactive approaches as identified in this study might indicate an acknowledgement of the patients' ability to self manage their own conditions and indicate a willingness, at the very least, to consider the idea of shared decision making. There is also a possibility that the proactive approach as described in this study might indicate an approach that is more likely to reduce some conditions from becoming chronic. The taxonomy of approaches identified in this research suggested that the doctors' approach might have implications for clinical care as these responses might be applied to other clinical conditions or the doctor may change from one response to another according to the situation they are faced with. Also it is possible that the doctor may change from one response to another within the consultation. This might prove to be an area for further research either in its own right or in relation to communication styles.

9.4 Trust

The approaches as outlined above suggest that the notion of trust might be a key issue for the doctor-patient relationship. Trust is an important but often taken for granted element at the heart of the doctor-patient relationship (Skirbekk, 2009). The concept of trust is an important one for human relationships and trust could be considered as the foundation of many human relationships and experiences (Stewart, 2001). The word 'trust' conjures up a variety of meanings such as being confident in the truth of something, trust in the reliability of a person or object to do what it is supposed to do or to feel safe in a relationship. This foundation is especially important for the doctor-patient relationship as, without the feelings of safety that trust creates, the patient would not be able to disclose the problems they face, allow physical examinations to be carried out and to undertake treatment (Fugelli, 2001; Skirbekk, 2008). At the same

time, it is important that doctors are also able to trust what their patients say (Rogers, 2002). While this applies in any practitioner relationship, in whiplash injury it is completely overshadowed by the prevalence of compensation seeking. This influences the expectations of both parties and what it does is create an immediate sense of mistrust on the part of some doctors. I mentioned to a colleague that my research was looking at whiplash injury and their immediate response was to associate this with injury compensation.

Compensation seeking is an important non-medical explanation that was used by some of the doctors to understand why patients came to see them with a whiplash injury and to account for those patients who experienced problems from it. The studies reviewed in chapter two, show the notion of compensation is used to explain the increase in numbers of whiplash injuries that were reported. The doctors in this study showed that they were aware that pursuing a claim of compensation might be one reason why patients sought medical attention. The doctors were aware that a patient would need to be given a diagnosis and have it documented before a compensation claim could be pursued. The fact that the doctors were aware of this aspect is not the same as perceiving it as being the primary reason for the consultation. However, there were some differences in the way this was seen between the doctors in this study. The doctors who worked in the A&E department felt they had seen an increase in the number of patients attending with whiplash injury. In contrast, with the exception of one GP, the doctors who worked in Primary Care did not perceive that there had been an increase in the number of patients they saw with whiplash injury or that seeking compensation was the main reason for attendance. One way that it might be possible to account for the differences in perceptions between the increase in numbers of

patients seen in the A&E department is that those patients who go to see their GP do so because they have continued to experience problems with their whiplash injury.

Compensation was also used to try and account for the fact that there were no obvious physical signs to explain the symptoms people presented with. As stated earlier, Schofferman and Wasserman (1994) found that patients who had a readily identifiable structural source for their pain were taken seriously by medical and legal communities. Whereas those whose cause of pain was considered to come from a soft tissue injury and diagnosed with a sprain or strain, were looked on disparagingly by the same medical and legal communities.

More recently Linnel and Easton (2006) looked at the influence of expectations and beliefs about whiplash injury and seeking compensation. They used the illness-perceptions framework developed by Leventhal (1998) in order to compare beliefs of individuals who were involved in litigation with the naive beliefs of individuals who had never suffered with the injury, to try and identify malingering behaviour whether or not litigation and treatment processes might be involved in the transition to a state of chronic ill health. Comparisons were made between individuals in a simulated group and a clinical sample of patients who had whiplash injury.

The simulator group were assigned to one of three scenarios: injury only scenario, injury plus compensation or malingerer scenario. In the malingerer scenario the participant had been told that they had been seen at the hospital and discharged with no injury. They were instructed to convince an insurer that they had suffered a whiplash injury in order to gain compensation. The findings were compared with a

clinical sample. They found that the range of symptoms experienced by whiplash sufferers was more adverse than naïve individuals would predict. They also found that those who suffered with the injury for a long time had more extreme negative beliefs than the participants who had been instructed to malingering dared suggest. Whilst sufferers' beliefs about the injury became more negative over time, their feelings of control over their symptoms improved. The study findings suggest that having a whiplash injury does not evoke an automatic belief in a protracted timeline. This is an important point to bear in mind when a patient presents with a whiplash injury, as it is not possible to differentiate between 'acute' or 'chronic' whiplash injury at the outset. The only distinguishing feature between 'acute' and 'chronic' was the timeline. Unsurprisingly, the malingerers were found to report the most extreme scores of all the groups. Whilst I think it is important to bear in mind that this group were specifically asked to deceive an insurer after being discharged from hospital with no injury, it does demonstrate the influence of compensation on the perception of the experience of symptoms.

Whilst the main focus of the influence of compensation appears to be on the patient, it actually influences both parties by creating a sense of mistrust. It almost creates a situation where people try and double guess what is happening. It is like a spiral of suspicion that gets in the way of the doctor-patient relationship through the loss of trust.

The notion of trust and the implications of what a lack of trust from the patient's perspective might mean for patient care has been the focus of interest within medicine. This has been particularly noticeable in trying to understand why patients

will or will not take treatment, or what it is that might make them distrustful of doctors. If trust is implicated in patient care it is reasonable to ask how or what the implications of a lack of trust by doctors might mean for patient care.

From an ethical position trust, or the preservation of trust, is a defining aspect of the doctor-patient relationship (Pellegrino, 1991). Skirbekk (2009) makes a distinction between implicit and explicit trust within the doctor-patient relationship. Explicit trust being that which is negotiated between two people, whereas implicit trust signifies that which is taken for granted. Skirbekk points out that, for patients, trust is rarely negotiated as unlike the doctor they are usually not in a position to do that. An implicit interpretation of trust takes place when the truthfulness of what is being said is taken at face value and this is seen as being a spontaneous reaction. This is not taken to mean that the doctor believes everything that is being said by the patient, but that they do not immediately question the patient's truthfulness. Skirbekk (2009:5) suggests that trust can be interpreted as a spontaneous reaction, whereas distrust can be interpreted as a result of experience. The issue of whether or not doctors trust what the patient has to say within the consultation will ultimately influence the approach taken by the doctor.

Rogers (2002) points out that certain aspects of the consultation are generally taken for granted as doctors usually assume that the patient is genuine when seeking care, that the patient will give an accurate account of their problems and that the patient will co-operate. In relation to medical care, trust concerns the shared aims of the consultation. This means that the patient has a desire to seek help for their illness and to understand and improve their health. All the patients in this study seemed to see the

doctor with those aims in mind and for that reason it would be expected that they would be considered as trustworthy. However, what this study found was that the doctors who took a dismissive approach towards patients with whiplash injury were more likely to be distrustful of the patients' motives. Rogers noted that doctors are more likely to have difficulty in believing patients with unusual or surprising symptoms. To overcome this difficulty it is suggested that the doctor needs to be able to suspend 'medical orthodoxy'. Symptoms such as pain and fatigue were identified as being more likely to create distrust. Distrust of the patients' account led to symptoms being discounted or labelled as 'medically unexplained'. If a patient has experienced the doctor's response to their concerns in this way or fears this kind of response it is possible that this might be a reason as why some patients do not go to see the doctor with complaints that they feel are not serious. An example of this would be symptoms such as changes in bowel habit that could also be seen as an early warning sign of bowel cancer.

As noted earlier, distrust is not a spontaneous interpretation but one that arises out of experience. This experience may be one that is related to previous knowledge of the patient and this might be an explanation of why a GP might come to distrust a patient but this would be less likely to be the case with doctors who work in the A&E department. Another experience that might lead doctors to distrust the patient's account is related to the idea of ulterior motives which may or may not involve financial gain and the doctors who took a dismissive approach were more likely to distrust their patient's account. Whilst it is difficult to say what distrust might mean for patient care it is hard to understand how a doctor who distrusts the patient's account can expect the patient to take the doctor seriously.

Chapter Ten: Conclusion

In chapter one I stated how my own experience of having a whiplash injury whilst working as a health visitor, was an important motivating factor that led me to undertake this study. Another important motivating factor that has helped me to maintain my commitment is belief that practitioners should conduct research that might be used to inform clinical practice. As noted earlier in chapter two my experience led me to question how whiplash injury was understood and treated during the initial consultation, whether or not this experience was implicated in it becoming a chronic condition and what this might mean for clinical practice.

My intention to draw on the patients' personal experience of whiplash injury to enhance and improve the clinical care that might be offered to people was also influenced by the many policy changes, such as The Patients Charter (Department of Health, 1992), that were taking place within the NHS during the 1990s, and the NHS Plan (2002). These changes promoted the principle of consumerism and the patient was turned into a customer with their own purchasing powers (Hardey, 1998). This meant that professionals like me were encouraged to engage with patients and to actively seek out their views on their healthcare experiences and has resulted in patient participation initiatives where specific aspects of healthcare form the focus of the review (Jackson et al., 2003). The patient or consumer is seen as an important voice as this allows questions to be raised that otherwise might not be considered (Tennant, 2001; Gherzi, 2002). These initiatives can be undertaken at the micro level of healthcare provision and be locally based, or they might take place at the macro or national level; for example the work undertaken by National Institute for Health and Clinical Excellence (NICE). Another aspect of these reforms was concerned with the

delivery of healthcare services and has led to a shift away from Secondary Care towards Primary Care as the key point of delivery for many services that are associated with the management of chronic conditions (Dept of Health, 2002). At the same time the increase in chronic conditions has also resulted in large numbers of people being excluded from work, and supporting people to return back to and remain at work is seen as a key aim of the Government's public health and welfare agenda (Waddell & Burton, 2006).

In this chapter, I am going to look at the implications of my findings in relation to these policies and I draw on those aspects of the healthcare experience that highlight a number of practical implications and recommendations that might assist healthcare providers with the management of whiplash injury. These aspects are concerned with the availability of resources to treat patients and the patients' responses to their healthcare experience. I also include my reflections on methodology. I will begin by highlighting the occupational implications of whiplash injury.

10.1. Occupational implications of whiplash injury

We saw in the literature in chapter two that having an illness that causes incapacity is no longer an automatic reason to be excluded work and that there is now pretty much a consensus that work is good for you for these reasons: It is associated with better physical health, mental health and emotional well being, work gives financial rewards, it gives social identity and status and provides a way of structuring time and it has led to the back to work agenda and certifying people as fit to work. Where does my research stand in relation to all this? Well it might be problematic as some might

read it and say it is countering the evidence because it appears to show that I am contradicting what has become a well established line. The back to work literature suggests that people should be encouraged not to see themselves as ill and to focus on what they can do and that they would be better getting back to work. I recognise that, by saying that it is important to take into account their subjective experience of even quite mundane things in their everyday lives, there is a danger that this could be interpreted as suggesting that in a sense you reinforce illness behaviours and the whole thrust of this policy is in the opposite direction. However, I want to make clear that there is a distinction between indulging their illness behaviours and trying to make sense, not just of what a symptom is on some kind of objective scale, but how it fits into a person's life world. It is not that they should be treated as more ill and therefore not sent back to work but, if we are going to get people to understand their condition in a way that enables them to work as much as possible, as a doctor it is necessary to understand their condition. My findings suggest that people do want to remain in work or to return to work as quickly as possible in spite of the difficulties they experience and that they will go to great lengths to do so.

It is important to restate the differences between the medical, biopsychosocial and phenomenological approaches to understand people's 'subjective health complaints'. The medical approach does not neglect physical symptoms but it deals with the experience of them in a non experiential way. Turning to the doctors' responses in chapter nine, an example of this could be the dismissive response. The symptoms from whiplash injury are not seen as significant. The biopsychosocial approach tends to treat physical symptoms only as information that is cognitively processed. It tends to focus on the way people think about them. The symptoms from whiplash injury are

not seen as significant. It is the way the person responds to their symptoms that is significant (see chapter two for a full discussion). In the phenomenological approach the symptoms are integral to the experience and we do not have to understand them just in terms of cognitive appraisal. This is important as the back-to-work literature focuses on work, meaning paid employment, and whether or not people can do the work in their paid employment, but their lives outside of work are also affected by it. Not only is that serious in itself but it may well impact on their whole orientation towards work as well. If you are experiencing constant discomfort at home or you are depressed because you can no longer relate to your family as you used to, then that is likely to have a wider impact. While the doctors were aware of the possibility that physical occupations might be problematic for some patients, there was no awareness of how the restrictions in movement that can be experienced with this injury might affect their lives outside of work or in other occupations.

10.2 Allocation of healthcare resources

This research highlights issues about access to services in whiplash injury and to understand this we need to look at healthcare resources. A major challenge faced by healthcare providers arises out of the huge demand for services. This means that decisions have to be made about the way in which resources are made available to treat a vast array of conditions and it is inevitable that this will lead to some form of rationing (Schmidt, 2004: Ham, 1995). Schmidt (2004: 970) defines the term rationing as any policy that will lead some patients to 'forego medically beneficial treatment within a collectively financed system of health care provision' such as the NHS. Rationing policies can be understood as being either implicit or explicit.

Schmidt (2004:971) draws attention to the UK as the country that was known for its politics of implicit rationing. Coast (1997) suggests that implicit rationing of healthcare takes place when care is limited and the decisions about the types of care provided or the basis for those decisions are not clearly expressed. An example of implicit rationing would be a waiting list or discharging someone earlier from hospital in order to free up a bed (Schmidt, 2004). Explicit rationing is seen as being the opposite of implicit rationing. The decisions about healthcare are clear, as are the reasons for those decisions. A classic example of this comes from America and is known as the Oregon approach. This arose out of the state's Medicaid programme and its refusal to fund a bone marrow transplant which was a young boy's only hope of survival (Strosberg et al., 1992). This led to the development of clearly defined packages of care which specified what services would be covered. Medicaid's failure to cover services at the 'lower end of the priority list' was the most controversial aspect of the plan (Strosberg et al., 1992:4). Another form of explicit rationing comes from the use of QALY. QALY stands for Quality Adjusted Life Years. It is a measure to capture both quality and quantity of life that involves a time trade off that is being used to make decisions on treatments for Low Back Pain (Gunzberg et al., 2005).

The turn towards the use of explicit rationing within the NHS can be seen with the establishment of NICE and the introduction of specific guidelines for treatment and in the way funding is allocated by the Department of Health to Primary Care Trusts (PCT) to commission a range of services to meet the needs of their local population. This funding is based on the relative need of the local population in line with identified health priorities. In turn local providers are commissioned to provide a range of services to meet those priorities (Johnson, 1999). The very fact that services

are geared to priorities suggests that some health conditions will not be seen as a priority and therefore services for these conditions will be limited.

The move towards explicit rationing has become a contentious issue, especially when it comes to treatment for specific conditions. For many people this means that they might not get the treatments they perceive as being necessary in enabling them to maintain their quality of life. This issue is clearly demonstrated in the treatment of Alzheimer's disease. The treatment of Alzheimer's has become a source of controversy due to the significant difference between NICE guidelines and the guidelines of the Scottish Intercollegiate Guidelines Network (SIGN). NICE (2007) guidelines for treating Alzheimer's recommend medication only for those people whose Alzheimer's is classed as moderate or severe whereas SIGN (2006) recommend that medication should be considered as a treatment for all people with Alzheimer's irrespective of severity as it is seen as enabling people to maintain their quality of life. Rationing of treatments for major life threatening conditions is a serious issue for patients and for doctors who look after patients with those conditions, so it should not be a surprise that this also applies to minor and non life threatening conditions. In that respect, by defining a condition as minor or even to use the term self limiting condition it means the types of resources that are made available to support healthcare professionals to carry out a range of treatment interventions will be limited. My findings suggest that some doctors may experience this as undermining their professional autonomy. In the past doctors would have been free to refer on to other health professionals where they felt necessary. Now they are limited to the extent in which they can do that. Although the present research is

focused on whiplash injuries some of these may well apply to other conditions that are labelled in the same way.

The doctors' accounts of treating their patients showed how they were limited in the range of interventions that were available for them to treat patients with whiplash injury and there were also differences in the way they dealt with the issue of rationing and whether or not this issue was brought to the attention of the patient. The effect of rationing was clearly demonstrated by the doctors' inability to make a referral to a physiotherapist (see chapter eight). This was because the criteria for referral to a physiotherapist were already laid down by the service provider and, in that sense, could be seen as being an example of an explicit form of rationing that leads to a two tier system of healthcare where only those patients who can afford to pay for their own treatment will be able to get it. This situation has the potential to pose an ethical dilemma for the doctor who has responsibilities to act in the best interests of their patient and, at the same time, has to manage finite healthcare resources (Lauridsen, 2009).

10.3 Implications for policy and clinical practice

What is considered a weakness in one situation can be considered a strength in another. An interpretative phenomenological study would be considered inappropriate by some (Darbyshire, 1994) for the production of a list of prescriptive recommendations. However the aim of this study was to provide a rich interpretation of what it means to have a whiplash injury from the patient's perspective and the influences of doctors and healthcare provision for that experience. Whilst

interpretative inquiry does not lend itself to generalisations in the sense of findings being statistically significant as would be the case with quantitative research, by using purposive sampling, which involves selecting participants whose experience is relevant to the research question (see chapter three for sampling and recruitment), it is possible to propose that the implications that have arisen from the participants' experiences might resonate in similar populations (Mason, 2004; Silverman, 2000). The findings have provided a unique insight that might prove to be beneficial for understanding the healthcare experience and assist in the provision of guidelines aimed at the treatment of whiplash injury.

The findings have highlighted a number of practical implications and suggestions that can be addressed by policy makers and individuals that pertain to the consultations that take place between a doctor and patient with a whiplash injury. The differing perspectives presented in this study have shown that the representation of whiplash injury as a minor physical condition that does not need medical attention, does not entirely accord with patient experience and highlights the importance of taking a holistic approach towards patients with whiplash injury and that this could also be applied to other conditions.

It is advocated that doctors adopt a subjective approach, that is, they take into account the patient's own personal or lived experience, when treating patients who have a whiplash injury. The reason for this is that it is only through asking patients about their lived experience, that a more accurate perception of the problems that are caused by the injury can be achieved. The findings from this study have highlighted how it is important to consider that a patient with whiplash injury might also suffer from a

psychological trauma as a result of their motor vehicle accident. This study has raised the possibility that the doctor might lack awareness of the psychological aspect of whiplash injury. This could indicate a need for further training and development in the area of psychological trauma and its management.

These are important considerations when advocating the types of interventions that patients might require for a full recovery to be made. Taking an approach that focuses on lived experience would also help to overcome the problem of competing definitions that are used to understand whiplash injury. It achieves this by setting aside medical preconceptions of what constitutes a whiplash injury by specifically looking at and responding to each individual's experience of symptoms.

Both doctor and patient accounts have highlighted how the different perceptions and management of the symptom of pain is a problematic area that might have long term implications and that pain was seen as being responsible for many of the problems that arise from whiplash injury. Some patient participants experienced the management of their symptoms as unhelpful and this may have contributed to their lasting nature.

One way that this situation might be overcome is through good education for doctors and patients about the importance of treating symptoms. Any guidelines for management of whiplash injury, need to be aimed at effective control and review of these symptoms during the acute phase of the injury as this appears to mean that patients have a better chance of not developing long term problems in the first place. The reason for a review of the symptoms during the acute phase would be to identify

those patients that continued to experience pain as the continued presence of pain is seen as being an indicator of a change from an acute to a chronic condition. This is important when looked at in relation to the recent policy changes about fitness to work and the management of common health problems (see chapter nine) that are associated with long term incapacity.

The patient participants draw attention to the lack of information that they were given on whiplash injury and what kind of problems it might create. The patients saw information as useful, enabling them to be more self reliant and better able to care for themselves. One of the problems here appears to be concerned with what is meant by information and whether or not the patient felt it helped them to make sense of their experience. The giving of information that enables patients both to make sense of, and be able to manage, their own self care has been recognised as an important healthcare intervention (Caress, 2003). The perceived lack of information by patients might be due to the possibility that the doctors thought that the diagnosis, which would be given verbally, was sufficient information in itself, whereas the patients wanted to know more about the different ways the injury might affect them and for how long and what they could do about it. This led some participants to adopt what Lambert and Loiselle (2009: 1006) describe as health information seeking behaviour. This behaviour is seen as being a key coping strategy in 'health-promotive activities and psychosocial adjustment to illness'.

10.4 Reflection on the research process

Interpretative phenomenology seeks a deeper understanding of phenomena through a detailed exploration of the way participants make sense of and understand their

personal situations and experiences (Van Manen, 1990). At the same time (Smith et al., 1997:70) it emphasises the dynamic relationship between researcher and participant within the research process.

Van Manen (1990:30) identified a structure of human science that gave me confidence to explore experience as it is lived. Through the promotion of freedom and the valuing of creativity, I have been able to engage in, and be changed by, this experience. When I commenced this research, I knew that both the data gathering and analysis phases would be challenging. This was because of my own personal experience. I was both a victim of whiplash injury and a healthcare professional (see chapter one). When I started interviewing I was using the interview guide too rigidly. However being rigid was beneficial to me as I needed to stay with my new role of researcher and not resume my usual role as a healthcare professional. This was particularly important when I was interviewing the doctors, as it would have been quite easy for me to relate to them as a healthcare professional and not as a researcher.

A major challenge that I have experienced with this research came from the requirement to suspend or bracket my own assumptions and knowledge to enable me to enter my participant experiences with an open mind. This sense of openness is necessary to gain new understandings and insights. Finlay (2008:1) describes this act of reflection and reflexivity as a dance, 'a tango'. I found the dance particularly hard to manage when the doctor was the participant. This is because the worlds that doctors and healthcare professionals inhabit are in some respects very similar and they also use the same language. My professional background meant that when I began this dance I would find myself using similar steps to the doctors. This can be seen in the

development of the initial template which had a similar structure to a medical consultation (see chapter seven for transformation of the templates that took place during the analysis of the doctors' data). This transformation emerged through the constant struggle to set aside and manage my pre-understandings and habitual ways of seeing the world.

Whilst I readily acknowledge that I am a novice researcher, I also acknowledge that many of the skills I have gained throughout my career as a healthcare professional have helped me to overcome this limitation and these skills have stood me in good stead. I have good communication skills and have developed sensitivity to the way people can respond in a variety of situations. This means I am both at ease with, and able to communicate well with, people in a variety of situations irrespective of age and professional or social standing. Working in a constantly changing environment and often in isolation from other members of the primary healthcare team has meant that I have developed resilience and have learned to trust and be guided by my intuition when working with people in their own homes. I believe that these skills have allowed me to engage in this research with confidence. Moreover, my ability to be open and responsive to people would have helped my participants to feel comfortable in my presence. This has led them to be open about their experiences and maintain their commitment to completing the study.

The chosen methodology has made me aware of the importance of the influences that I personally brought to the research and the way these impacted on the generation and analysis of the data. When I first started to think about this project, I had thought that I would need to be seen as being separate and detached from the research if it was to

have any value. Having completed this project I now find it hard to understand how any researcher can believe that they do not have a personal influence on any research that they are involved with.

10.5 Dissemination of findings

The process of dissemination of findings began with a poster presentation at the British Psychological Society inaugural Qualitative Research Conference held in 2008. This research also forms the basis for one of the case studies used in the Requallo online learning project (Gibbs and Lewin, 2005) to demonstrate the specific use of template analysis in qualitative research. As part of the process of future dissemination I intend to make presentations of the findings to the local trust boards. These are the three audiences that I would like to write for: the social sciences e.g., Qualitative Health Research and British Journal of Health Psychology, the academic health services such as, BMJ, Emergency Medicine Journal and Advanced Nursing, and finally to professional non-refereed journals as they would reach a wider audience in an easy to read style.

10.6 Recommendations for further research

This study suggests that there are several aspects of the patient and doctor experience that might benefit from further research. There are types of whiplash experience that are likely be missing from my sample. As discussed in chapter four, patient participants were only included if they fulfilled the selection criteria. This meant that the sample I chose to interview was limited to the experiences of the working

population. A common motivation for patient participants to take part was to enable the healthcare system to be more aware of their problems and to improve patient care in the future. Whilst their stories were unique, their experiences were very similar and it would be useful in future research to include people who also feel that they have recovered. I would also like to carry out a future study that looks at the experiences of people who were aged sixty five and over as different issues may have emerged.

There are types of whiplash experience that are also likely to be missing from the research as new or recently qualified doctors declined to take part in the study. A lot of the writing about whiplash injury and back to work is quite recent and for that reason it might be useful to interview people at different parts of their career because there has been a change in the information provided to doctors. Building on my research I would specifically like to examine the following topics as they might provide additional insight into the doctor-patient relationship:

1. The dismissive, reactive or proactive approaches might also be experienced in other chronic conditions and further in-depth studies would provide a deeper understanding of what these responses might mean for patient care.
2. The study suggested that trust seemed to be a key issue for the healthcare experience. Whilst there has been considerable research that looks at how much patients trust their doctors, there has been little that looks at doctors trusting patients therefore this kind of study of trust could be carried out. While it would be useful to carry out some large scale surveys on this issue we also need detailed studies on the meaning and experience of this kind of trust.
3. This research has shown the intertwining of a psychological injury with the physical aspect of whiplash injury. Further investigation into this might offer

more insight and give further support for the value of the patient's subjective experience for understanding illness.

10.7 Conclusion

I started this research from two perspectives: one of being a health professional and the other of being a victim of whiplash and through this journey a few things stand out. The first and most important point is that by listening to and valuing people's own experiences; healthcare professionals are able to achieve a greater understanding of their patient's experience. My belief that patients' own experiences provide valuable sources of information that healthcare professionals should seek to enhance or change practice has been validated and strengthened through interpretative phenomenology.

Interpretive phenomenology provides a theoretical foundation that is, at the very least, equal to and able to challenge more 'traditional scientific foundations' through its focus on meaning. People's lived experience becomes a legitimate focus that can be explored in a way that is denied when using more traditional forms of biomedical research. This means that the person can be looked at holistically by looking at lived experience that is not broken down into biological, psychological or social aspects. This is important as it is never either; it is always all of these.

At the beginning of my journey, I began by wanting to make sense of my own experience of whiplash and to understand the problems that I experienced. My foray into the literature showed that little was known about the psychosocial implications of whiplash injury and there were no studies that had conducted in-depth qualitative

research with patients who had sustained a whiplash injury or looked at both patient and doctors' perspectives of the injury. By listening to patients' accounts of their experiences, a rich understanding of the psychosocial experience of whiplash injury and an alternative, but equally credible, way of understanding the malfunctioning body has emerged. Triangulation of doctor and patient views has identified three different approaches: dismissive, reactive and proactive, that a doctor might take towards patient concerns and revealed potential implications of the particular approach for the doctor–patient relationship. This kind of research can help to show the importance of the psychological dimension to whiplash injury and doubtless to other illnesses as well and suspect that if this is neglected it could be in part responsible for delay in recovery.

It is my hope that healthcare professionals and others who read this work, will feel inspired and encouraged to really listen to their patients' or clients' lived experiences and to undertake similar research in their own field of work and clinical practice.

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Appendices

Appendix One: Letter to trust Chief Executives

Headed Notepaper

Dear

My name is Frances Rogers and I have recently enrolled as a part time research student at the University of Huddersfield. I am writing to ask if your organisation could support me in carrying out my MPhil/PhD research project as I would need to interview both patients and staff.

My interest in whiplash injury arose out of my own personal experience of having a whiplash injury following a car accident at work. After a short spell of sick leave I returned to my duties as a Team Leader /Health Visitor and eighteen months after the accident I was still experiencing physical difficulties and developed psychological problems with driving. Whilst I am now recovered from the psychological problems I still have physical problems associated with pain and movements. Due to my personal experience of whiplash injury and professional background I believe that many of the long-term psychological and social consequences can be minimised by appropriate health care interventions.

I am enclosing a copy of my research proposal which I have used for my enrolment along with my CV and would be happy to discuss this with yourself or other members of the trust.

I look forward to hearing from you and enclose a SAE for your reply

Yours sincerely

Frances Rogers
MSc SRN RHV.

Appendix Two: Invitation for patient recruitment

Headed Notepaper

Patient Recruitment

Mrs Frances Rogers
Research Student
Tel xxxxx xxxxxx
Department of Behavioural Sciences
frances@roge12.freeserve.co.uk
f.d.rogers@hud.ac.uk

Dear Dr

The experience of whiplash injury

A research study into the Experience of Whiplash Injury and How It Is Affected By Health Care Provision is being carried out in Huddersfield as part of a PhD study at the University of Huddersfield in collaboration with Calderdale & Huddersfield NHS Trust & Huddersfield Central and South Huddersfield Primary Care Trusts. The study seeks to improve our understanding of the experience of whiplash injury, its affect on the long term well being of the individual and their family and the role that healthcare provision plays in that experience. We require two groups of participants, group one, will consist of patients and group two, will consist of doctors. We require thirty patients to be volunteers to take part in a prospective study of twelve months duration to identify what that experience is. We are writing to ask whether you could help us in recruiting patients to this study.

What will happen to the patients

Patients will undergo three in-depth interviews as follows; first interview, second interview at three months post and final interview at twelve months following inclusion into the Study. The interview will cover the following areas: The nature of the accident, the experience of healthcare, affects on lifestyle, driving, employment, current coping strategies and litigation status.

A follow up telephone interview will take place six months into the study to see if there have been any further changes.

What type of patients do we want to recruit

We require willing patients who have been in a motor vehicle accident and have sustained a whiplash injury.

We would not ask you to recruit patients who come under the following categories:

They have been involved in an accident in which a fatality has occurred or other occupants are in a life threatening situation. They have sustained other more serious injuries than their whiplash injury. There is a history of mental illness such as schizophrenia or major depression. They have a learning difficulty. A medical condition such as rheumatoid arthritis or other such condition, which could affect their injury. They have a major medical condition and they are under 18 years of age and over 65 years of age. Or any patients whom you believe through your clinical judgement and personal knowledge of them leads you to believe that they would be adversely affected by taking part in the study.

What will you be required to do

You will need to select 3 patients who have had a whiplash injury in the six months period prior to the commencement of the study and 2 patients who have had a whiplash injury during the three month period following commencement of the study. You will be required to give consent forms and information sheets to whiplash injured patients who have either attended the A&E dept or your surgery for medical attention or advice.

Why are we asking you

Your practice is one of six practices chosen to help recruit participants to the study, as we are seeking to reflect the diverse nature of the general practice population. To do this we are recruiting practices from the inner city, urban and rural areas of Huddersfield.

What will happen now

I will contact you within the next two weeks to ask whether you would be involved in patient recruitment and to answer any questions you may have about the research. You are not obliged to take part in the study if you do not want your patients to be involved.

If you require any further information before then please feel free to contact me either by telephone or email and I shall be pleased to help.

Thank you for any help that you may be able to give

Yours faithfully

Frances Rogers (Researcher)

Appendix Three: Whiplash study recruitment practice guide

Whiplash study recruitment

For GP to do:

Prospective patients presenting within 2 weeks of a motor vehicle accident.

- Make the diagnosis
- Ensure doesn't possess an exclusion criterion
- Introduce the study
- Give info pack including consent forms
- Ask pt to complete forms in their own time and send back to Frances in sae. Keep a record of the name in table below.

Retrospective patients

- Do a search on whiplash between May and October 2003-~~05~~-11
- Identify patients
- Exclude if exclusion criteria apply
- Send a pack to the patient and keep a record of the name in table below

Date	name	Emis number	Given pack Y/N	

Exclusion criteria.

- They have been involved in a motor vehicle accident in which a fatality has occurred or other occupants are in a life threatening situation
- They have sustained other more serious injuries besides their whiplash injury
- They have a history of mental illness such as schizophrenia or major depression
- They have a learning difficulty
- They have a medical condition such as rheumatoid arthritis, which may affect their injury
- They have a major medical condition
- They are under 18 and over 65 years of age.
- Any patient whom the GP believes would be adversely affected by taking part in the study.

Appendix Four: Patient information

Patient Information

Study into the experience of whiplash injury

You are being invited to take part in this study with the University of Huddersfield in collaboration with Calderdale and Huddersfield NHS Trust and Huddersfield Central and South Huddersfield Primary Care Trusts.

We would like to know about your experience of having a whiplash injury.

We are currently asking for suitable volunteers to be involved in the study.

Would you like to be a participant?

Should you wish to be a participant in this study we would require you to give consent for you to be contacted.

To give consent to your details being disclosed to the researcher please complete and sign the two consent forms. One copy is to be kept by yourself and the second copy to be returned in the prepaid envelope provided.

Should you agree to take part in this study, the researcher would contact you by telephone to arrange a convenient time to meet you and confirm the arrangement in writing.

Before you decide, please read through the details of the study carefully. The following details explain what will happen to you if you are selected as a participant for the study

Title

The experience of whiplash injury.

Please read:

You are being invited to take part in a research study run by the University of Huddersfield in collaboration with Calderdale and Huddersfield NHS Trust and Huddersfield Central and South Huddersfield Primary Care Trusts. Before you decide to take part, it is important for you to understand why the research is being done and what will be involved. Please take time to read the following information carefully and to discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like further information. Take time to decide whether or not you would like to take part in this study. Thank you for reading this.

Purpose of study

Whiplash injury is a minor injury that appears to be on the increase and occurs as a result of a motor vehicle accident.

The purpose of this study is to look at your experience of the injury and of your recovery from it.

The study is being carried out to increase our knowledge and understanding of whiplash injury and how it affects individuals. The knowledge that we get from you may be used to inform health care interventions and the types of service that may be required to manage this condition.

What will I have to do?

The study will involve a series of four interviews over a period of twelve months. The researcher will come to interview you at a time and place that suits you. Three of the interviews will take about an hour and with your agreement will be taped, the other interview will be by telephone. The first interview will take place when you agree to take part in the study and will take about 1 hour. The second interview will be three months later and will take about an hour. The third interview will be by telephone at six months and the final interview will take place twelve months after the start of the study and will take about an hour. A copy of your interview transcripts will be given back to you. Before the interview you will be required to sign two consent forms, one for you to keep and one for the researcher.

Do I have to take part?

No to be involved in the study is completely voluntary. You should not feel obliged to take part. It is entirely up to you to decide whether or not to take part. Your doctor will not be told whether you agree to take part or not.

What will happen if I decide to take part?

If you wish to take part in the study, sign the acceptance form and return it in the pre paid envelope. When we receive your acceptance form, the researcher involved with the study (Mrs Frances Rogers), will contact you within the next two weeks. She will arrange a time to come and talk to you. The interview will be informal and friendly allowing you to choose what you wish to say. You will not be asked to talk about anything which you may find uncomfortable. The conversation will be taped and will be kept in strict confidence. It will only be available to those involved in the study. Your name will be replaced by a code on written documents. This means that you will not be identified. The code will only be known to the researcher. The interviewer will arrange to interview you at a time convenient to you.

What happens if you change your mind?

You may withdraw at any time from the study and you do not have to give an explanation for your withdrawal.

Why have you been asked to take part?

You have been asked to take part as you have recently had medical attention for a whiplash injury.

Who else will participate in the study?

We would like to interview thirty people who have had a whiplash injury.

What will happen to the results of the research study?

The taped conversations will be transcribed and analysed for common themes. Once analysed findings from the interviews will be presented in a report to the University of Huddersfield, Calderdale and Huddersfield NHS Trust, Huddersfield Central and South Huddersfield Primary Care Trusts and to interested health professionals. All patient information in these reports will be strictly anonymous.

Who organised and funded the research?

The University of Huddersfield in collaboration with the Calderdale and Huddersfield NHS Trust, Huddersfield Central and South Huddersfield Primary Care Groups.

Who has reviewed the study?

The University of Huddersfield ethics committee and Calderdale and Huddersfield ethics committee have both reviewed and accepted the study on grounds of acceptable ethical standards.

Contact for further information

If you would like to talk to any body or receive any information on the study then please contact your GP. Alternatively you can contact the researcher involved with the study Mrs Frances Rogers, School of Human and Health Sciences, The University of Huddersfield, HD1 3DH mobile xxxxxxxxxx

Thank you for taking the time to read the above.

Appendix Five: Patient ‘study’ acceptance form

Headed Notepaper

Participant Acceptance Form

MAY 2002

The experience of whiplash injury

You should retain a copy of this form when completed

1. I have read the patient information sheet
2. I would like to be contacted by the researcher of this study to arrange a time and place to be interviewed.
3. Personal details : name -----

d.o.b -----

male / female

Address -----

contact number -----

Signed -----Date-----

Name in Block Capitals-----

Appendix Six: Study confirmation

Headed Notepaper

Department of Behavioural Sciences

Dear

The experience of whiplash injury

Thank you for agreeing to take part in this study.

I am writing to confirm the date and time of our interview for this study is -----

If you have any questions before we meet please feel free to contact me on mobile

xxxxxxxxxxx

I look forward to meeting you.

Yours sincerely

Mrs Frances Rogers (Researcher)

Appendix Seven: Participant consent form

Headed Notepaper

PARTICIPANT CONSENT FORM

MAY 2002

The experience of whiplash injury

You should retain a copy of this consent form when completed

- | | |
|---|-----|
| 1. I have read the patient information sheet. | Y/N |
| 2. I understand what will happen to me during the study. | Y/N |
| 3. I have had the opportunity to ask questions and discuss the study. | Y/N |
| 4. I understand that I am free to withdraw from the study after it has started at any time without having to give a reason. | Y/N |
| 5. I understand that anonymous data from this study may be used for future research purposes by the lead researcher | Y/N |
| 6. I agree to take part in the study. | Y/N |

Signed -----Date-----

Name in block capitals -----

Witness signature-----

Appendix Eight: LREC Approval

Martine Stephenson - Huddersfield LREC Administrator
Infection Control Secretary, Pathology Dept.
(Direct Line Tel: 01484 347272)

Huddersfield Royal Infirmary
Lindley
Huddersfield
HD3 3EA

Huddersfield Local Research Ethics Committee
Chairman - Dr G Sobala

Tel: 01484 342000
Fax: 01484 342888

36/2002 - Please quote this number on all correspondence

Our Ref: GS/MAS
03 September 2002

Mrs F Rogers
5 Alwen Avenue
Birkby
HUDDERSFIELD
HD2 2SJ

Dear Mrs Rogers

Re: The Experience of Whiplash Injury

The Huddersfield LREC request that the Patient Information Sheet and Consent Form should be placed on to appropriate headed paper and would request a copy of the above to be sent for its records. With this proviso, the study has been approved.

Huddersfield LREC abides by the Guidelines for Good Clinical Practice (International Conference on Harmonisation).

No deviations from, or changes of, the protocol should be initiated without prior written LREC approval/favourable opinion of an appropriate amendment, except when necessary to eliminate immediate hazards to the subjects or when the change(s) involves only logistical or administrative aspects of the trial (e.g. change of monitor(s), telephone number(s)).

The investigator should promptly report to the LREC:

- (a) deviations from, or changes of, the protocol to eliminate immediate hazards to the trial subjects.
- (b) changes increasing the risk to subjects and/or protocol affecting significantly the conduct of the trial
- (c) all adverse drug reactions (ADRs) that are both serious and unexpected.
- (d) new information that may affect adversely the safety of the subjects or the conduct of the trial.

You must now register your Study with the *R&D Department to gain Trust approval before you can start this Study. The Committee will be interested to be kept informed of your progress and look forward to receiving your annual report.

Yours sincerely



Martine Stephenson
LREC Administrator

Chairman: Gordon M. McLean Chief Executive: Diane Whittingham



Appendix Nine: PCT Approval

SUE BAXTER, HEAD OF SERVICE IMPROVEMENT
Directorate of Patient Experience
South Huddersfield PCT
St Luke's House
St Luke's Hospital

Direct Line: (01484) 466228
Email: Susan.Baxter@southhuddersfield-pct.nhs.uk

South Huddersfield 
Primary Care Trust

St. Luke's House
Blackmoorfoot Road
Crosland Moor
Huddersfield
West Yorkshire
HD4 5RH

Tel: 01484 466000
Fax: 01484 466111
Minicom: 01484 466153

Mrs F Rogers
5 Alwen Avenue
Birkby
Huddersfield
HD2 2SJ

Re: The Experience of Whiplash Injury

11 July 2003

Dear Frances

I am delighted to inform you that your project has gained organisational approval and you can proceed with your research, across South Huddersfield PCT. Should you require further assistance / information with any administrative aspect of the project, do not hesitate to contact me.

Our research governance management arrangements are hosted by the Research and Development Department at Calderdale & Huddersfield NHS Trust.

When visiting practices to carryout your research, please note that you will need to hold an honorary contract with each practice, which includes a statement on Research Governance.

Kind regards

Sue Baxter
Head of Service Improvement

Chairman: John Chilton
Chief Executive: Judith Holbrey

Appendix Ten: Patient participant follow up

Headed Notepaper

Dear Patient

Your doctor, on my behalf, recently sent you an information pack inviting you to take part in the study the experience of whiplash injury.
If you have sent the reply back thank you.

If you have not, I would be grateful if you could let me know whether you are willing to take part. Please tick the Yes or No box below and provide your contact details if you are willing.

The interview is completely anonymous and confidential. This means that you will not be identified in any way from the tape recordings or the written report.

Any future treatment you may need will not be affected in any way by your decision.

A stamped addressed envelope is enclosed for your reply

Yes I would like to take part

Personal details : name -----
male / female -----
Address -----

contact number -----

I would like another copy of the pack please tick this box

No I would not like to take part

Thank you for your time.

Yours sincerely

Mrs Frances Rogers

Appendix Eleven: Interview guide ‘patient’ first interview

Interview Guide For Whiplash Injury Study (Patients)

First Interview

Section One: The Accident.

1. Can you tell me about the accident?
Yes continue
No. probe is that because you are too upset?
2. When did you seek medical treatment?
3. Where did you go for treatment?
4. Why did you go for treatment?
5. How were you taken for treatment?

Section Two: Experience of Healthcare

1. Who did you see?
2. What treatment were you given?
3. What information were you given?
4. What advice were you given?
5. How do you feel about your healthcare experience?
Probe for effectiveness?
Helpfulness?
Appropriateness?

Section Three: Psychological experience

1. Has the accident affected your concentration in any way?
Probe for examples
2. Has your sleeping pattern changed?
If yes: in what way?
Why do you think that is?
3. How do you feel about the accident?
(Angry, guilty)
4. Does the injury cause you any pain?

5. Can you tell me about your pain?
6. How would you describe that pain?
On a scale of 1–10 where 1 is low and 10 is high how would you rate the strength of your pain.
7. What are you taking for your pain and how often?
8. What other methods / strategies do you use for managing your pain?
9. What do you feel is the best method for managing your pain?

Section Four: Social Situation

1. How does the injury affect your life at present?
(What can't you do now?)
Daily activities
Leisure activities
Work activity (sick leave)
Any change in mood etc
Relationships
Probe for consequences
2. Has the accident affected your driving in any way?
Can you describe how it has changed?
3. Has the accident changed how you feel in the car?
In what way?
Why do you think that is?
Can you tell me how it is now?
What were you like before the accident?
4. Do you have any worries or anxieties about the accident?
Probe look for examples
5. Are you claiming compensation?
What are your reasons for this?

Section Five: Recovery

1. Would you describe yourself as recovered from your injuries?
If yes: why is that? Then go to Q5
If no: why is that? Then go to Q2
2. How are you managing with your injury at present?
3. What do you do to make it easier for yourself?

4. What do you think would help?
5. On the whole what do you think has been the biggest impact of your injury for yourself and your family?

Appendix Twelve: Interview guide ‘patient’ follow up

Interview Guide For Whiplash Injury Study (Patients)

Follow Up Interview Three Months & Twelve Months

A resume of previous responses will be made available prior to the interview

Section One: General update on situation

1. How are things since we last met?
2. Is there any change in your condition?
(If same or worse Q3)
If improvement ask in what way
If recovered ask when
3. Are you seeing anyone at present regarding your injury?
If yes: who?
If no: why not?
Do you feel that you should?
4. Are you on any treatment at the moment?
If yes: what treatment do you have now?
Who recommended?
5. How do you feel about your healthcare experience now?

Section two: Psychological experience

1. Is your concentration still affected in any way?
If yes: ask how
2. Has your sleeping pattern changed?
If yes: ask how
3. How do you feel about the accident now?
4. Do you still have any pain from your injury?
If no: go to question 1 social situation
5. Can you tell me about your pain?
6. How would you describe that pain?
On a scale of 1-10 rate the severity
7. What are you taking for your pain relief?
Who do you see for your pain?

8. What other methods / strategies do you use for managing your pain?
9. What do you feel is the best method for managing your pain?

Section Three: Social Situation

1. How does the injury affect your life at present?
Daily Activities
Leisure activities
Work activity
Moods
Relationships
2. Has the accident affected your driving in any way?
Can you describe how it has changed?
3. Has the accident changed how you feel in the car?
If No got to Q5
In what way?
Why do you think that is?
Can you tell me how it is now?
4. What were you like before the accident?
5. Compensation
Review situation
Ask about the experience and how it makes them feel

Section Five: Recovery

1. Would you describe yourself as recovered from your injuries?
If yes: why is that? Then go to Q5
If no: why is that? Then go to Q2
2. How are you managing with your injury?
3. What do you do to make it easier for yourself?
4. What do you think would help you now?
5. On the whole what do you think has been the impact of your injury for yourself and your family?

Appendix Thirteen: Telephone interview ‘patient’

Telephone Interview Six Months

1. Has there been any change in your condition since we last met?
If yes what
2. At your last interview you were still experiencing pain
Do you still have pain?
Rate the pain scale 1-10

If no pain at last interview ask if that is still the case
3. Are you still having treatment or have you started any treatment?
4. Ask about sleeping pattern
5. Are you back at work or doing usual activities?
6. Ask about driving?
How do you feel about driving now?
7. Can you tell me what the single most troublesome aspect of your injury is for you at present?

Appendix Fourteen: Interview guide doctors

Interview Guide For Whiplash Injury Study Doctors

1. Can you tell me what whiplash injury means for you?
2. Can you tell me about your experience of treating whiplash injuries?
3. Can you tell me if you have had experience of treating whiplash injuries on a follow up basis?
4. Can you tell me about a patient who didn't recover as quickly as you would have expected them to? And why you think that happened? If no can you tell me why a whiplash injury might take longer to recover than you would expect it
5. Have you any thoughts as to why there are more whiplash injuries

Appendix 15: Initial template patient data

Initial Template for Whiplash Injury

Perception of Seriousness of Accident

- this time minor in nature

History of Whiplash

- Current/recent incident – detailed description of accident –emotional reaction
Chronology of symptoms
- Previous incidents- impact on recent injury - flare up
- Previous treatments Physiotherapy didn't work NHS & Private
Osteopath
Acupuncture was effective

Current/Recent Symptoms

- Headaches Initial dismissal of symptoms
- Back Pain twinges Pain unspecific
- Stiffness in neck
- Feeling heavy and useless
- Comparison to normal mobility

Seeking Help

- 2 or 3 days after accident
- Health care system generally inadequate help
- GP- basic examination / assessment
- Lack of expert advice now / previously
- Osteopath used before considered going back
- Physio Long wait for non urgent
- Acupuncturist not aware of availability given previously by physio

Initial Consultation

- prescribed anti-inflammatory
- no anticipatory guidance or advice on what to do

Treatment

Type of medication – anti-inflammatory (NSAI)

OTC pain killers

Unhelpful

- Anti inflammatory Adverse Reaction- surgery advised to discontinue
- In the past TENS didn't work

Helpful

- OTC pain killers
- Previous Acupuncture

Exacerbating Factors

- Cold weather
- Physical response to pain (how hold head or movements etc)

Self Management

Helpful

- Warmth : hot baths, wheat bags
- Avoid draughts
- Wrap up use scarves
- OTC medicines
- Avoid carrying & lifting heavy things
- Pilates prior to current RTA
- Being sensible taking care – implies personal responsibility
- Aromatherapy (lavender oil)
- Exercises

Unhelpful

- Swimming (only does breaststroke)

Knowledge of Whiplash

- Familiarity with symptoms
- What to avoid – certain movements
- Aware of risk from latest RTA

- Hoping not to suffer
- To rest but not go to bed

Impact on lifestyle

- Stopped activities
- Stopped doing Pilates too painful
- Stopped walking dog
- Stopped walking
- Stopped going to the gym
- Struggles hanging washing out, polishing etc
- Partner took over cooking
- Partner took over helping son with homework
- Going to bed early

Emotional Changes

- Moody bad tempered home and work
- Partner also bad tempered
- Tired not sleeping
- Exhausted

Impact on Work

- Computing, took more breaks
- Rest time actually lie down
- No lifting or carrying
- Stopped driving

Sick Leave

- Didn't have sick leave.
- Change in Sick leave policy
- Felt would have done

Impact on Driving/Travelling

- More tense in car

- Thinks other will hit the car
- More cautious
- Heightened awareness of what is around
- Constantly looking (hypervigilance)
- Feels a safer driver now

Pain

- Doesn't get better
- There all the time

Pain Management

- Not to take drugs all the time
- Other therapies can help
- Trial and error
- Keep warm
- Heat warm baths wheat bags lavender oil
- Acupuncture in the past
- At work Change positions lie down take a walk

Bodily Changes

- Restricted movements
- Weakness in some movements
- Weight gain 21 lbs
- Had to think about movements

Recovery Period

- Not recovered 5 months since accident
- Never fully recover always there
- Takes over a year

Compensation

- Took legal advice
- Not claiming this time
- In the past stressful process

Changing Image of self

- Sedentary not as active
- Feels older 60 not 40
- Compares to how used to be
-

Biggest Impact From Injury

- General health
- Physical activities like standing etc

Other Service Providers

- Physiotherapy
- Osteopath
- Alexander Therapist
- Accessibility of services
- NHS long waiting lists
- Private expensive

Attitude To Injury

- Feels affect of injury not taken seriously
- Doesn't warrant a referral to other services
- Sees it as a chronic condition

What Will Help

- More information from GP
- Availability of physiotherapy
- Advice on self management
- Alternatives to drugs
- Become an area of weakness
- Take steps to prevent postural changes
- Long time to correct when changes become established
- Pain affects body movements

Narrative Style Elements

- Use stories to illustrate impact
- Detailed descriptions re symptoms
- Trying to convey the feeling (physicality)
- Heroic story line- don't like taking medication do with out

Stoicism- just get on with it

Appendix Sixteen: Revised template (doctors)

Revised Template (Doctors)

1 Whiplash injury: The Official Response

Immediate response to describe injury

Associated with a car accident

1.1 Differences between doctors in A&E and Primary care

Frequency in whiplash injuries seen

Inappropriate use of A&E

2 Whiplash injury: Nothing to worry about

Specific pain and stiffness symptoms

As a patient with no accompanying psychological reaction to the accident

As a patient who will get better little or no medical intervention

3 Whiplash injury: Its problematic nature rocks the boat

Small chance may require extended medical intervention

As a patient whose symptoms might interfere with work

Manual work

Care work

Not as a person whose symptoms might interfere with domestic roles

3.1 Making sense of uncertain nature

Patient's contribution to situation

Patient has personal responsibility

A patient who is reluctant to take medication

A patient who does not take the doctor's advice

Patient not to blame

A patient who has problems tolerating certain medications

3.2 Is it still a whiplash injury?

Use of knowledge and personal experience

Research findings

Experienced a whiplash injury

Not just a patient with a neck problem

As a patient who might have other health problems

As a patient who might become depressed

3.3 Medicalization of whiplash injury

A patient encouraged to return by doctors

As a person who develops illness behaviour

As a person who might adopt the sick role

Trajectory

4 Suspicious: Ulterior motive

As a patient whose condition is a construction of injury compensation systems

As a person who is under pressure to make a claim

As a person who sees the injury as an opportunity to make money

As a person seeking justice

5 What doctors do

5.1 Deal with patients

To see patients with a whiplash injury

To identify and document the injury

To prescribe treatment to relieve symptoms, in particular pain relief

5.2 Encourage patient to help self

To advise and reassure the patient

To encourage the patient to keep mobile through exercise etc

To encourage the patient to self manage

5.3 To use NHS resources appropriately