

# *Phenomenology of Professional Practices in Education and Health Care: An Empirical Investigation*

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## Abstract

In this article a group of professionals working in education and health care explore professional practices and interactions from a phenomenological perspective, drawing on Max van Manen's conceptualization of the phenomenology of practice and his knowledge interest in understanding and furthering sensitive, caring professional practice. Posing the question ***what is the meaning of interaction in encounters within education and health care***, we look at practice experiences drawn from close observations and interviews during research concerning special needs education, physiotherapy and weight loss programs. Three anecdotes are offered as a way to 'show,' rather than interpret, the processes involved. Each anecdote is followed by reflections in which we draw on van Manen's notion of pathic knowledge and Nancy's ideas about co-existence to develop phenomenological insights about temporal, embodied and relational qualities of the phenomenon of interaction in professional practice. Such interaction seems to involve continuous negotiation. It emerges as a process of exchange, a movement back and forth between supporting and letting oneself be supported; between confronting and being confronted; between pushing and being pushed. Moments of active

engagement give way to periods of waiting for the other to act. The experience is one of continuous back and forth movement in the relational space in-between.

**Keywords:** *professional practice, health care, education, pathic knowledge, co-existence, embodied interaction, placement and dis-placement*

In this article we explore the meaning of interaction in education and health care encounters from a phenomenological perspective. Our exploration is based on cooperative research by scholars with professional backgrounds in the health sciences and education, all of whom share an interest in phenomenology, in particular Max van Manen's perspectives on professional practice (van Manen, 1977; 1991; 2014).

We detect a visible line running through van Manen's work from his early conceptualization of education and phenomenological pedagogy (van Manen, 1977, 1982) through his methodological bestseller *Researching lived experience* (van Manen, 1990) to his recent book *Phenomenology of practice* (van Manen, 2014). Throughout, he reveals a specific *research interest*, one that:

... address[es] and serve[s] the practices of professional practitioners as well as the quotidian practices of everyday life. More specifically, this phenomenology of practice is meant to refer to the practice of phenomenological research and writing that reflects on and in practice, and prepares for practice (van Manen, 2014, p. 15).

As the latter part of this quote suggests, there is a strong link between this research interest and professional practice. There is therefore also a *knowledge interest* in van Manen's work that seeks to understand and further sensitive and caring professional practice; one that:

... depends on the sense and sensuality of the body, personal presence, relational perceptiveness, tact for knowing what to say and do in contingent situations, thoughtful routines and practices, and other aspects of knowledge that are in part prereflective, pre-theoretic, pre-linguistic (van Manen, 2007, p. 20).

Existing research on the experiences of those receiving health care or health-related special education, while quite extensive, tends to originate from specific and distinct professional contexts, whether education, nursing or physiotherapy. Within each professional discipline, the focus of research has been on clients' or students' experiences (although some researchers have also paid attention to the experiences of caregivers and teachers). In the case of special needs education, for example, Sævi (2005) investigated lived experiences of students with intellectual disabilities (and their significant others) in pedagogical encounters. Goodwin (2001) explored the perspectives of students with physical disabilities in research on the meaning of help in elementary school physical education; by analyzing the various meanings that were assigned to being helped, Goodwin was able to provide a nuanced picture of students' experiences. Vagle (2010) researched teachers' experiences of becoming aware that there was something students did not understand during teaching sessions.

In the field of health care, research has been conducted into the experiences of people living with different medical conditions. Examples include studies by Råheim and Håland (2006) in relation to fibromyalgia; Bjorbækmo and Engelsrud (2008) in relation to experiences

of motion in everyday life by children with serious congenital heart disease; and Ekra and Gjengedal (2012) on children's experiences of being hospitalized after a diagnosis of chronic illness. In an earlier study, Gjengedal (1994) examined the experiences of severely ill patients who had been attached to a respirator, along with the experiences of those taking care of them.

Other researchers have investigated experiences of living with obesity (Rugseth, 2011; Rugseth & Standal, 2015) and with long-term bodily changes following weight loss (Groven, Råheim, & Engelsrud, 2015) or bariatric surgery (Groven, Galdas, & Solbrække, 2015; Natvik, 2015). Bjorbækmo and Engelsrud (2010) explored the experiences of children with physical disabilities (and those of their parents) in relation to testing within healthcare settings.

Thus far, however, few studies have investigated the meaning of interaction in these professional encounters (exceptions include work by Bjorbækmo & Mengshoel (2015) and Ozolins, Dahlberg, Hörberg, & Engelsrud (2011)).

To examine relational aspects of a phenomenon is to ask how people or things are connected (van Manen, 2014, p. 303). For the purposes of our cooperative research, we posed the question: *what is the interaction/connection between professionals and patients/ students like in education and health care encounters?*

## Professional Practices and Pathic Knowledge

A phenomenology of practice, argues van Manen (2007, p.13), “aims to open up possibilities for creating formative relations between being and acting, between who we are and how we act, between thoughtfulness and tact.”

In his early work, van Manen (1993) explored the concept of *tact*, which he saw as having three central meanings. Firstly, the word's etymology suggests that tact refers to the sense of touch or feeling; in this sense, tact is related to touching or being in touch, as in the word ‘tactile.’ A second meaning emerges in the sphere of music, where tact is used to describe the orchestration of several instruments. Thirdly, tact has to do with the ability to deal carefully and diplomatically with delicate situations.

This trio of meanings suggests that tact has multiple levels of meaning in both education and health care. The concept embraces a practitioner's ability not only to use touch but also to be *in touch* with their patient or student. It relates to their ability to tune into individual rhythms and co-create situations in ways that meet individual needs. For van Manen, tact is about understanding the meaning and significance of the situation and then acting (by knowing and doing) in ways that are ethically appropriate (van Manen, 1993).

One aspect of practical knowledge of particular relevance here is van Manen's concept of *pathic knowledge* (van Manen, 1996; van Manen & Li, 2002). As the name suggests, this type of knowledge is related to sympathy and empathy and as such constitutes a form of inter-subjective relationship. The practitioner's knowledge is pathic in the sense that it depends on “presence, relational perceptiveness, tact, and other aspects of pre-reflective, pre-theoretical, pre-linguistic knowledge” (van Manen & Li, 2002, p. 217). It is this kind of knowledge that helps practitioners become attuned to professional situations and the experiential dimensions of those with whom they are interacting. For van Manen and Li (2002), pathic knowledge is the embodied knowing which provides a corporeal sense of ourselves, things and others.

Pathic knowledge can take a variety of several forms:

- *Actional knowing*: knowledge expressed (for instance) through personal styles of teaching as well as through habits and kinesthetic memories.
- *Temporal knowing*: knowledge that the present is a projection of past knowledge towards the future. Temporal knowing is expressed through intentions, inclinations and orientations.

- *Corporeal knowing*: knowledge gained in and through our bodies.
- *Situational knowing*: knowledge of ourselves in relation to the world around us and how we interact with it.
- *Relational knowing*: knowledge linked to, or informed by, the relationships we form with others.

While these aspects of pathic knowledge should be understood as interwoven, we are particularly interested in the situational and relational aspects of professional practice. In this article, we focus on interaction in professional practices, which we describe as inter-personal practices.

## **Exploring Possible Human Experiences – A Science of Examples**

Van Manen provides a methodology by which research into lived experience can generate human science knowledge of relevance to education and health care (van Manen, 2007; 2014). The means by which this knowledge is generated are the same as those van Manen sees as necessary for developing pedagogical tact in teachers. They include using personal experience; being sensitive to language (including etymology and idiomatic expressions); interviewing or closely observing others; and attending to experiential descriptions in literature.

In line with van Manen's (2014) recommendations, our aim is to explore and understand possible human experiences. In this article, we draw on experiential anecdotes from three different research projects. The anecdotes are developed from close observations and interviews done in education and health care settings.

As all the authors of this article are either educators or health care professionals, our research has involved a basic challenge: that of unearthing and confronting our own presuppositions and prejudices about the practices we have studied. In an effort to see things afresh, we have sought to reveal our habitual ways of thinking about the practices explored in the paper, and the roles of the various players involved, whether practitioner, student, patient or researcher (Finlay, 2002). The collaborative nature of this project, in which we closely scrutinized each other's work, aided our practice of epoché, a central component of phenomenological reflection and analysis. The epoché involves parenthesizing or bracketing various assumptions that might stand in the way of opening up and making apparent the "living meaning" of a phenomenon (van Manen, 2014).

Phenomenology may be described as the science of examples. For van Manen (2017, p. 814), the "phenomenological example" is one of "something knowable or understandable that may not be directly sayable." It provides access to a phenomenon in its singularity and makes the "singular" knowable and understandable. Consequently, for an anecdote or example to be powerful it should bring experience vividly into presence, so that the reader can unreflectively recognize the experiential possibilities of human life (van Manen, 2014, p. 241). The example should "let the singular be seen" (van Manen, 2017, p. 815).

In phenomenological writing, the challenge or problem is not about "how to get from text to meaning but how get from meaning to text" (van Manen, 2017, p. 813). For van Manen, writing and rewriting are central to phenomenological research as it goes about systematically exploring meaning structures of the actual phenomenon, situation or event while always seeking expressive means to grasp the pre-reflective substrata of the actual experience. In

phenomenological research, data generation, analysis and writing are intertwined. During the process of writing and rewriting, the epoché and the reduction enable the researcher to attend to an attitude that involves a fascination with the moment, with the uniqueness of an experience or event. While the epoché involves opening up and freeing oneself from obstacles in order to approach the phenomena of our lifeworld, the reduction is about engaging a reflective phenomenological attitude, one which seeks to address the uniqueness of the phenomenon as it shows itself in its singularity (van Manen, 2014, p. 228). Reflecting on the moment or event that has made us wonder demands patience as well as the ability and willingness to discover and understand the unexpected.

Below, we present three anecdotes drawn from three specific professional situations we have researched. In developing, creating and writing the anecdotes, we have sought to *show*, rather than interpret or “tell” the meaning of these experiences by gently fictionalizing actual empirical case studies. Our aim here has been to offer more plausible descriptions, and we do not believe such editing makes for less trustworthy accounts. We seek to evoke the particular, to alert readers to the singularity of the event or moment, while acknowledging the possibility that one person’s experience may have elements in common with that of others.

### **Shared Interacting in Professional Practices - An Experience of Continuous Negotiation**

Our three anecdotes follow a similar structure. Firstly, the research context from which the anecdote is taken is briefly presented by the researcher concerned (‘I’). The anecdote is then presented in italicized text, with fictive names used for the professional and the patient/ student. Each anecdote is then followed by our reflections.

#### ***Dora and the Nutritionist: To Interact is to Confront and be Confronted***

This anecdote has its origins in a research project on the experience of being fat (Rugseth, 2011). Dora is one of 16 participants recruited from a lifestyle treatment program located at a hospital. She is married, has three kids and works part-time as a cook at a nursing home. I interview her about what she calls her “lifelong struggle with being fat.” The interview takes place in her living room. She serves me her favorite tea and delicious homemade scones. During the interview Dora invites me to join her the following week at one of her monthly 20-minute consultations with a nutritionist engaged in the treatment program. She is expected to send her food diary from the week before and jokes that she must jot down in it the homemade scones we have just shared.

*Dora is in the nutritionist's office. She sits upright on the chair, her back straight, wearing a frozen expression. The nutritionist is reading something on her computer*

*and pays Dora no attention. Then she looks up and greets Dora with a hasty smile.*

*"You made pasta for dinner last Thursday," she states. "Too many carbs could be a problem if you want to lose weight." "I know," says Dora, "but I watch the portion size." "What about the sauce?" the nutritionist continues. "Do you add a lot of cream to it?" "No, of course not," Dora answers. "I work as a cook, I know a lot about how to make pasta sauce without too many calories." The*

*nutritionist looks at Dora, pauses for a second and then says: "If you knew a lot about making food without too many calories, Dora, you wouldn't be here trying to lose weight, would you?"*

What is the interaction like in this encounter between Dora and the nutritionist? What constitute its inter-acting dimensions? What exactly is the nature of the connection between patient and professional? Is there a connection, or is it a dis-connection?

From the very beginning there is a felt tension in the room. It is felt through the patient's bodily expression: one of being on the alert. On the alert for something to come? The professional begins by turning all her attention to her computer screen. In bodily terms, she is turned away from the patient, and the relational space between them is open – open in the sense of waiting for possible actions, connections and interactions. At the very beginning of the session, contact between them is on hold, although both seem to bodily notice each other's presence.

When the nutritionist finishes reading and turns to look at her patient, she begins by raising an issue related to Dora's food diary: the fact that she's eaten pasta. The patient avoids responding directly to what she is confronted with by focusing on the size of the portion she has eaten. Is she offering opposition to the nutritionist's confrontational comment? The professional resists in a similar way by not responding to the importance of the size of the pasta portion. Instead she focuses on whether there was a lot of cream in the pasta sauce. The situation is more reminiscent of a battle than of a co-operative interaction towards a shared goal.

As the situation develops, the nutritionist's response becomes increasingly confrontational. By the end her words take up all the space; filling the room, they freeze the interaction between herself and her patient, creating a space in-between that is a demand to stop. The words being said hang like a shadow over the situation, over the relationship between the professional and her patient. To confront and be confronted is like pushing and being pushed. Here, the pushing and being pushed is "hard enough" to bring the relational situation to a standstill.

We are stopped by surprise, rebellion, humiliation. But we are also stopped by wonder, followed perhaps by the possibility of reorientation.

To interact in professional encounters (whether in education or health-care contexts) is to explore topics of common interest. In the case of weight loss programs, two distinct perspectives feed into that shared interest. Both the individual seeking to lose weight and the professional aiming to support that process are understood to share an interest in achieving the same predetermined goal. For Dora, this becomes part of what she calls her "lifelong struggle of being fat." We might assume this also to mean her "lifelong struggle to lose weight." But are the two statements in fact equivalent?

The inter-dependency of professional and patient/student when it comes to achieving the presumed shared goal of treatment/education challenges them to connect, get in touch with one another and cooperate. During encounters, the professional is expected to provide care that helps the patient/student achieve their aims. But an individual's presence at a treatment program or an educational course may not tell us what that individual actually wants to achieve. That applies even in the case of a person joining a weight loss program. In Dora's case, for example, might her lived experience of being fat (which she describes as a "lifelong struggle") be in conflict with her experience of being in a weight reduction program?

A tense situation is created when a patient is confronted with having done something at variance with professional advice (eating pasta, in Dora's case). On the practitioner's side, the situation reveals a lack of professional success in convincing the other to act as recommended. Both parties become visible to themselves and each other as "unsuccessful." Nevertheless, the professional has a special responsibility to establish an interaction, to achieve a degree of

collaboration that makes it possible for the patient to succeed. That is the basis on which the professional succeeds as well.

In the anecdote, the interaction/ conversation takes place in a professional context: that of a hospital-based weight loss treatment program. Such a context contains “ready-made-meanings” (Merleau-Ponty, 2005, p. 213): for example, about what it takes to lose weight. Both what we say and how we say it carry meaning; they make our understandings and knowledge visible. As van Manen observes (with reference to Merleau-Ponty), “Language bears the meaning of our thoughts as a footprint signifies the movement and effort of a body” (van Manen, 2014, p. 29). “Our knowledge manifests itself in practical actions; it reveals itself through our tone of voice, how we smile (or don’t smile), and our manner of looking the other in the eye” (van Manen, 2014, p. 270).

Van Manen argues that a medically grounded professional perspective, focused on gnostic insights, cannot produce pathic experiences (van Manen, 2014, p. 281). Nor is such a perspective likely to produce a sense of togetherness between professional and patient; an interaction geared to achieving the stated goal. While such an interaction requires each party to move towards the other, the professional carries a special responsibility to move towards her patient, to displace herself so as to try to see the situation from the perspective of the other. The aim is not to be the other, but rather to be a fellow human who wants to understand and offer care.

In Dora’s case, the space in-between the professional and the patient was one whose lived experience consisted of confronting (the nutritionist) and being confronted (Dora). Dora was confronted with being someone who had failed to comply with the “rules of the game” by deviating from professional advice.

Some questions arise here. Are confrontation and being confronted – being pulled and pushed into confronting oneself with a certain view of a “reality” -- purely the result or outcome of gnostic knowledge? As practices, are they always untactful, negative or cruel? Does pathic practice never involve confronting or being confronted? In this first anecdote, we do not learn what happened after the climax, when interaction between professional and patient was brought to a standstill. Perhaps the lived experience of confronting and being confronted, of pulling and being pulled to face non-compliance with treatment or pedagogic argument provides an open space for possible future action, interaction and re-orientation.

### ***Sara and her Teacher: To Interact is Also to Wait***

I am involved in an ongoing research project into how embodied meaning unfolds in school when students have severe, multiple disabilities. I have created the following anecdote from close observations conducted in a special needs education unit that is part of a Norwegian primary school in a suburban area. The unit has a maximum of eight students, all with severe cognitive and sensory difficulties as well as somatic and health-related difficulties.

Twelve-year-old Sara lies in a corner in the largest classroom. At this time of day, the other students are occupied in other rooms or at the other end of the classroom, and the space around Sara is calm and quiet. She lies in a solid wooden structure, a sort of baby crib-cum-playpen, that her dad has made for her to use at school: it is square shaped, with each side about two meters long, and reaches about one and a half meters above the floor. Inside lie blankets, soft toys (including teddies), pillows and a feeding bottle.

*Sara lies on her back with her feet pulled all the way up to her belly. She makes prolonged, deep toned wailing sounds. Anna, Sara's teacher, climbs into the wooden structure and sits down. She faces Sara, stretches out her legs and*

*gestures that she wants Sara to sit up. Then she grasps Sara's hands and tries to drag her upper body towards her own. Sara resists. She withdraws her hands, stays lying down and continues wailing.*

*After a couple of minutes, Sara stops wailing. Anna places her hands firmly under Sara's armpits and guides her gently to a sitting position. Anna then lies on her back, trying to pull Sara with her so that she'll rest belly down on Anna's body: the two of them will be stomach to stomach, chest to chest, face to face. Sara resists. She turns her face away, lies down on her back again and continues to wail monotonously. The minutes pass by. Anna waits quietly. All of a sudden, Sara stops wailing and climbs into Anna's lap. Their faces are close. Sara's slants her head. In a low voice Anna starts slowly to sing:*

*Row, row, row your boat,  
gently down the stream.  
Merrily, merrily, merrily, merrily,  
life is but a dream.*

*Sara sways from side to side, following the rhythm of the song. Anna sings the verse over and over again and then stops. Shortly afterwards, Sara stops swaying and sits still for a while. Then she begins to sway again. Immediately, Anna resumes her singing.*

In this example, interaction takes place within an educational context which demands that the professional attune to her student if a meaningful relationship is to occur. But when the teacher several times attempts to involve her student in an interaction, the student actively rejects her invitations. The intimate bodily approach used by the teacher to attempt to start an interaction is not accepted by her student who rejects being enrolled this way. After several attempts, the teacher accepts this non-compliance. She sits still and waits. From actively trying to pull her student into a relational interaction with her, the teacher changes her approach to one of waiting. As she sits and waits she remains bodily close to her student; they are still very near one another. The teacher's waiting is an active waiting. Her attention is still directed towards her student as she waits.

Waiting for someone while being physically close and quiet creates space for the other to act. It is an invitation to Sara to respond to her teacher's waiting and to their shared situation. Eventually the student accepts this opening by climbing into her teacher's lap. From then on, their interaction takes off in another form: doing together, stopping, waiting, then taking the initiative to continue the activity they share.

The situation embraces different bodies that try to relate to another in sameness and in difference. At the same time, the relation rests upon the teacher's approach: one of allowing the student to accept the invitation to close, embodied contact when she is ready. Their interaction alternates between engagement and (active) disengagement; first one and then the other take the lead. The teacher's active waiting opens up a space in which her student can tell her that she wants their interaction to continue. Her wish is expressed not only by the swaying but also by the situation as a whole: one of movement and absence of movement, co-created and incorporated by bodies in close proximity to one another. This creates a relation where both parties are included in an embodied exchange of perspectives, a conversation. Here, waiting for the student (active waiting) has the effect of pushing and pulling the student into actively engaging in a mutual interaction and a shared activity.



## ***Tracy and the Physiotherapist: To Interact is to Take Risks***

The following anecdote derives from a research project exploring physiotherapists' experiences of helping patients diagnosed with obesity to make lifestyle changes, particularly those geared to reducing weight. Most of the activities are group-based, with patients encouraged to participate in them.

In my interview with Ingvild, one of the participating physiotherapists, she recalls a situation she had experienced as challenging. Had she made the right professional decision by encouraging Tracy (one of the participating patients) to join the rest of the group on a long outdoor walk?

*Today we are going for a long walk. Tracy is eager to participate but concerned about the pain she suffers in her knees and feet. She shares her concern with me (her physiotherapist), arguing that as she might not be able make it all the way there and back it might be better if she opted for a shorter walk. "The trip is not that long, and the terrain is OK," I assure her. "I really think you should join the rest of the group." Tracy nods and says she will give it a try.*

*We start walking. When we reach the half-way mark and turn to go back, Tracy confronts me. "How could you!" she says. "I can't understand how you could recommend this trip to me. It's not okay for my legs and my feet-- it's very painful. I've no idea how I'm going to walk all the way back. No way is this a good experience for me."*

*Despite this, Tracy manages to walk all the way back.*

*My own thoughts – and doubts -- run back and forth. Had I assessed her capacity correctly? Had I made the correct professional decision?*

*A day or two later I meet Tracy again. "I became very tired during the long walk," she tells me. "My legs and feet ached a lot, but the pain didn't last for long and it hasn't got any worse after the trip." Then she adds: "I want to thank you for believing in me, for believing I could manage the trip."*

This anecdote describes a situation in which a professional encourages us to do something and assures us that we will manage to do it. Being trusted to be capable of undertaking a long walk is a call to comply with a professional's advice and recommendation. Even if we doubt our own capacity, the professional's assurances and encouragement will be of great importance to our decision, which might override our own judgment (and fears). Being seen as able by a professional invites us to see ourselves as capable – and to trust the professional's judgment concerning our capability. Our sense of being trusted to have the needed capacity makes us believe that we can indeed 'walk the walk.' Pulled to believe we can, we dare to do as recommended. Like Tracy, we take the chance, even if this means putting ourselves at risk.

In the professional spheres of teaching, caring and medical treatment, convincing the patient/student to take a risk forms part of a process. Sometimes it may result in the patient/student believing that doing the recommended action is simpler than it actually is. When we experience it as hard to do and difficult to complete, we may get angry and upset. We may regard the professional as incapable of giving us the right advice and perhaps

incapable of seeing us as we really are. It may seem to us that the professional cannot judge our capacity and lacks perception of our concerns and problems. A feeling of being not seen, of being misjudged, comes to the fore, perhaps leaving us with a sense of being misunderstood.

In the anecdote, the relationship between Tracy and her physiotherapist shifts from trust to mistrust and then back again. After encouraging her patient to go on the walk, the physiotherapist finds herself confronted with the possibility of having made completely the wrong recommendation. Later, however, her patient thanks her for the trust placed in her ability to complete the trip. The therapist moves from stated certainty to uncertainty about own judgment skills and finally to thankfulness for being believed in -- and relief at not having made a completely wrong decision.

Interaction between a professional and a patient/student seems to involve continuous negotiation. It emerges as a process of exchange, a movement back and forth between supporting and letting oneself be supported; between convincing and being convinced; between confronting and being confronted; between pushing and being pushed. Moments of active engagement give way to periods of waiting for the other to act. The experience is one of continuous back and forth movement in the relational space in-between.

For the professional seeking to encourage a patient/student to push themselves to the limit, interaction involves taking chances; it involves pulling and pushing to see what the individual can handle and tolerate. For the patient or student, too, it's about taking chances, even if they feel uncertain about the outcome and their ability to live up to expectations. Here trust in the professional can enable a patient/student to experience a felt moment of "I can" – a felt confidence that makes it possible to grasp the chance, rely on the professional judgment, and also to rely on oneself.

### **Professional Practice: Movement Between Placing and Displacing Oneself in Togetherness**

The findings of our study shed light on the possible meaning structure of interaction in professional encounters in the fields of education and health care. This meaning structure can be characterized as a back and forth motion between experiences of pushing and been pushed, of pulling and been pulled. Involved in the push/pull and pushed/pulled experiences are various nuances of inter-related lived experience. Interaction unfolds in time and space as a dynamic counterbalancing embodied co-existence enveloped within these meaning structures. At times, the parties may experience moments of togetherness and harmony, of equilibrium and flow in respect of communication and action. At other times, interaction and co-existence are experienced as dis-attuned and headed towards potential breakdown.

In professional encounters, the professional and the patient/student co-exist; the experience of each is personal as well as shared. As Merleau-Ponty (2005, p.416) notes, "Co-existence must in all cases be experienced on both sides." In professional encounters, the shared dimension of the experience demands that both parties continuously displace themselves. It requires both professional and patient/student to shift position and move towards the other in order to maintain and develop the collaboration.

Nancy (2000) argues that togetherness implies being in contact, and that getting in contact demands displacement. In this sense, being "with" is not enough, since "with does not indicate the sharing of a common situation any more than the juxtaposition of pure exteriorities does (for example, a bench with a tree with a dog with a passer-by)" (p. 35). In such instances, "with" is the sharing of time and space and nothing more. With and being together do not indicate a sharing of a common situation, merely the fact of being present in the same place at

the same time. It is the dis-position in between people, things and the environment that opens a possibility—or not—for togetherness and the sharing of a situation.

However, in a situation involving two individuals in contact, neither can take the other's space, place or perspective. Here, the sharing of a situation demands both individuals to shift position. Establishing contact requires the willingness of both parties to move towards one another. Displacing oneself towards the other may involve movements forward, backward, sideways, or even up and down. It is about adjusting one's "steps" according to the placement and displacement of the other. Tactful practices involve such adjustments and moves every time practitioners attempt to attune to the uniqueness of a patient/student and to grasp the experiential dimensions of those with whom they are interacting.

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