Notes on Evaluating the Ecology of Rehabilitation Praxis

By Thomas A. Schwandt

Abstract: Rehabilitation services are typically regarded as an intervention, delivered by a professional service provider, designed to achieve the outcome of functional improvement in the life of the client or patient. The primary evaluation question is whether that intervention is an effective and efficient means to the given end of functional improvement. I suggest an alternative way of thinking of both rehabilitation and evaluation: The phrase 'ecology of rehabilitation praxis' is used to emphasize that rehabilitation is a matter of a situated, lived, technical, moral, and political interaction of people with their environment, with each other, and with the artifacts of their environment. Three conceptual tools are discussed for understanding the ecology of rehabilitation praxis: community-based practice philosophy, community of practice, and the discursive nature of a practice. When rehabilitation is conceived as ecology, and not simply a treatment, then a different way of thinking about evaluation is required.

Notes on Evaluating the Ecology of Rehabilitation Praxis

A common approach to evaluating rehabilitation services follows the logic of a biomedical model of clinical research. Rehabilitation services are regarded as a treatment or intervention, delivered by some professional service provider, designed to achieve the particular outcome or effect of functional improvement. The aim of evaluation is to determine whether, in fact, the treatment is producing that effect, and if so, to what degree.

The provision of rehabilitation as a treatment, regardless of the specific nature of individual rehabilitation services, involves three, and possibly four, kinds of care services which are thought to contribute to the outcome of functional improvement: (a) technical care—applying medical science and technology; (b) interpersonal care—treating patients/clients with consideration, respecting patient/client autonomy, listening to patient/client concerns, and so on; (c) amenities of care—providing services in a clean, comfortable, and aesthetically pleasing setting (Eldar, 2000). In the current ideology of providing medical services,

we might even add a fourth kind of 'care' that involves imparting competence and confidence to disabled individuals to participate in their rehabilitation. These four attributes of the professional service are regarded as measurable (and ideally, quantifiable).

To evaluate the relationship between treatment (care services) and outcome, two approaches are employed. In one approach, different kinds of treatment are compared to one another to determine whether the outcome is attributable to the treatment. For example, the treatment-effect relationship can be examined in an institutional setting versus a community-placed setting. These kinds of comparison are relevant because rehabilitation services are delivered in complicated contexts where resources of time and money, professional competence, types of patient problems, and so on vary and might affect the treatment-outcome relationship. Likewise, follow-up studies can be conducted to determine whether the outcome of functional improvement is long-lasting; different combinations of professional services can be evaluated for their contribution to the outcome, and so on.

In a second approach, standards are developed for each attribute and performance is measured against the standard. Of course, standards for technical care are often more easily established, and more precisely measurable, than standards for interpersonal care, the amenities of care, and the imparting of confidence to patients, but this is considered to be largely a methodological problem, not a serious threat to the logic of the model.

This way of thinking of the relationship between evaluation and rehabilitation focuses our attention on the efficacy and strength of the intervention. Evaluation here is a *technical* task: It is a matter of using research tools to assess the means-end relationship or to measure performance against a standard. In either case, the evaluator plays a role similar to that of the clinical medical researcher, using the procedures of social scientific research to examine this relationship between the provision of rehabilitation services and the outcome of functional improvement. To briefly summarize: The object of interest to evaluation in the treatment-effect model is the provision of rehabilitation service as an intervention into the lives of patients/clients. The primary question about that object is whether it is an effective means to the given end of functional improvement.

In what follows, I discuss how we might go about thinking of evaluating not an object but a lived, situated practice; something that is always unfolding as a performance, always in the process of being accomplished or achieved. I have chosen the phrase *ecology of rehabilitation praxis* to emphasize the fact that the provision of

rehabilitation services is a matter of the situated, lived interaction of people with their environment, with each other, and with the artifacts of their environment. (One might say the principal difference here is between rehabilitation as an outcome and *rehabilitating* as a process.) Moreover, that interaction has technical, moral, and political dimensions. My central thesis is that when rehabilitation is conceived as ecology, and not simply an object, then a different way of thinking about evaluation is required. Thus, my purpose is to two-fold: First, I sketch an understanding of the ecology of rehabilitation praxis in Norway, and second discuss a way of thinking about and conducting evaluation that matches this ecology.

Towards an Ecology of Praxis Model

In a model assuming the ecology of rehabilitation praxis, evaluation focuses on the discursive, positioned enactment of rehabilitation in all of its complexity[1]. The primary questions addressed in this way of thinking about evaluation are not technical, means-end questions, but value-rational questions about the ways rehabilitation practices are and should be organized and conducted. These kinds of questions simultaneously take up issues of both the means and ends of a practice.

To understand how different the matter of evaluating rehabilitation as an ecology of praxis is from evaluating it as an object, I explore briefly three conceptual tools for understanding the ecology of rehabilitation praxis: community-based practice ideology, community of practice, and the discursive nature of a practice.

Community-Based Practice

In my judgment, the Norwegian way of approaching the provision of health care services to its citizens reflects a general philosophy of rehabilitation as community-based practice (NOU, 1998, 2001; Sosial- og Helsedepartementet, n.d.). Community-based practice is not simply a strategy for relocating services from centralized institutional settings to more local community-placed settings; rather, it is a way of redefining the technical, political, and moral dimensions of the very idea of *rehabilitation*. It is a shorthand way of referring to a different ecology of relations between professionals, citizens, and society. This way of thinking is characterized by several key ideas (Kendall, Buys, and Larner, 2000):

First, it emphasizes the competence and participation of citizens in decisions influencing their existence as members of society. This is a complex idea that holds together two potentially paradoxical notions. On the one hand, it emphasizes the empowerment of the individual citizen; the right and capacity of an individual to be an independent, autonomous participant in all aspects of

social life, and capable of mastery and control over her or his own life. The notion of *citizen* is key here because it marks a shift away from thinking of the individual who receives a particular kind of social or health service as a consumer or buyer. Empowerment also refers to something like a state of being, a capacity that all citizens have—not some right or capability that is bestowed upon them by others. To be empowered is to be able to exercise one's capacity for self-determination. On the other hand, the key to such empowerment is connectedness and interdependence with others in a local community. Empowerment thus does not mean that an individual is left to her or his own devices; rather that he or she works together, in consort with, other members of a local community.

Second, this philosophy emphasizes inclusion of all citizens within a community. Inclusion here refers to the shift from a custodial and medical care model of health services design and delivery to a community development model. This is more than a notion of community-*placed* services for it refers to the combined efforts of disabled people, their families and communities, and the appropriate professional service providers to orchestrate rehabilitation.

Third, the philosophy challenges the model of restorative care. Community-based practice signals a holistic and individualized orientation to rehabilitation and a move away from a custodial and exclusively restorative approach to rehabilitation. Rehabilitation becomes not a matter of 'healing' the sick but of providing services that allow people to realize their capacities to develop.

Fourth, the philosophy promotes the development of a different identity and way of working for rehabilitation professionals. A common fear is that this philosophy of community-based practice challenges, and even threatens to destroy, the identity of medical care and health service professionals. On the contrary, what is emphasized here is the creation of a new, additional identity, new models for the use of best practice technical medical care, and a new ethic of professional-citizen relations for those who collectively consider themselves rehabilitation professionals.

Community of Practice

A second conceptual tool that helps us develop an understanding of the ecology of rehabilitation praxis is drawn from the work of Etienne Wenger (1998). A community of practice is a social group engaged in the sustained pursuit of a shared purpose. The group is characterized by mutual engagement; it is a negotiated enterprise; and, it draws on a shared repertoire of resources (routines, sensibilities, artifacts, vocabulary, styles, and so on). Practice is a way of negotiating meaning through social action. Wenger identifies five characteristics of a community of practice.

Members of such a community: (a) interact more intensively with and know more about others *in* the community than those *outside* the community; (b) hold actions accountable more to the community's joint enterprise than to some other enterprise; (c) are more able to evaluate actions of other members of their community than the actions of those outside the community; (d) draw on locally produced resources and artifacts to negotiate meaning more so than resources and artifacts imported from outside the community; and, (e) share an identity.

Communities of practice are local and discrete and not coterminous with professional groups. For example, the primary care physicians in a particular hospital share a common institutional environment, have a shared history, and interact with one another around important issues they face regarding patient care in that setting. While they share the professional identity and goal of *physician* and thus are broadly related to other physicians, they share membership in this particular, discrete, local community of practice. Taken collectively, these various discrete communities of practice constitute a constellation of communities of practices.

This notion of community of practice is significant for understanding the ecology of rehabilitation praxis. Local communities of practice are not likely to reflect within themselves a deep understanding of different ways of seeing a phenomenon such as rehabilitation. In fact the closer one is to the center of a community of practice (i.e., the more one is considered a full member) the less likely one is to develop a heterogeneous and varied understanding of different ways to think about rehabilitation. Each community, be it that of primary care physicians, nurses of various kinds, physiotherapists, social workers, municipal officials, and so on has its own way of seeing and its own tools and procedures for making sense of the phenomenon. Thus, part of the pedagogical task of understanding and evaluating the ecology of rehabilitation praxis is learning how to educate each community of practice in the views of others.

Precisely because multiple communities of practice are involved in rehabilitation as an orchestrated social process there will inevitably be complex value conflicts and conflicting practice norms. While these norms and practice vocabularies do pose limitations on negotiation, a full understanding of the ecology of rehabilitation practice suggests that what might be the object of evaluation is not simply the provision of a professional treatment or intervention but the development of different models for professional work and the negotiation of an ethic of relationship between service providers and between service providers and citizens (Lindqvist and Tamm, 1999).

Again, the evaluation task here is pedagogical, not technical; for it will involve helping various members of disparate communities of practice (nurses, physicians, social workers, physiotherapists, and so on) constitute another community of practice—a community of *rehabilitation* professionals organized around the joint enterprise of community-based rehabilitation practice.

Discourse of a Practice

One additional analytic tool for making sense of the ecology of rehabilitation praxis is that of the discourse of a practice. A discourse is an institutionalized use of language and language-like sign systems that takes place at cultural, political, and professional levels. It is a public process through which meanings are progressively and dynamically achieved. Discourses can compete with one another and create distinct and incompatible visions of reality (Davies and Harre, 1990).

Regarded as a multifaceted set of discourses, rehabilitation is not merely a service provided by a professional but a way of seeing and thinking about phenomena (Solvang, 2000). A great deal of what is a stake in evaluating holistic rehabilitation praxis is learning how the new discourse of holistic rehabilitation praxis is intersecting with medical discourses of normalization or normality that have long dominated ways of thinking about what it means to be disabled or in need of rehabilitation.

In addition, evaluation here would involve examining how, and how effective, professionals are in opening their respective discourses to public scrutiny. Evaluation focused on discourse helps us see the importance of the provision of rehabilitation as an ethical-political relationship, not merely the delivery of a medical service—a particular way of valuing others and of envisioning the responsibilities we have towards them.

An Evaluation Approach for the Ecology of Rehabilitation Praxis

I turn now to the implications of this focus on the ecology of rehabilitation praxis for evaluation. Specifically, I discuss three ideas: 1) a different way of thinking about what evaluation is, 2) a different way of thinking about the questions that define the purpose of an evaluation, 3) a different way of thinking about the responsibilities, roles, and obligations of parties (stakeholders) in an evaluation.

Thinking Differently About Evaluation

The evaluation logic sketched at the beginning of this paper would have us view the social world as in some way at our disposal in a manner similar to how the physical sciences regard the natural world. What are evaluated are object-like entities (in the evaluation literature there is a special name for these kinds

of objects—*evaluands*) with properties that can be observed, described, classified, and measured. These objects (an individual educational plan, a particular social service, a medical treatment, and so on) are regarded as tangible such that it becomes possible to talk of observing their outcomes, documenting their effects, tracking changes in their behavior, as well as auditing their performance. Evaluation serves as a means—a tool, a procedure—for generating two types of knowledge about these objects: theoretical knowledge of cause and effect, or technical knowledge of effective means.

Now consider evaluation as another way we are in the world. Let us begin with the assumption that all evaluation activity is fundamentally engaged, concrete, indigenous, and experienced (as *Erfahrung*) as opposed to abstract, disengaged, or somehow removed from the erratic, contentious, uncertain, ambiguous, and generally untidy character of life itself. This means that all judgments of the value (merit, worth, or significance) of human action are undertaken within specific places and circumstances where these judgments both reflect and depend upon the thinking (including socio-economic, political, and moral values) and acting of the specific parties involved at the distinct time and place in question. Moreover, in the particular circumstances where some group of people is attempting to decide whether they are doing the right thing and doing it well, their various interpretations are almost always contested, never certain, and forever subject to reinterpretation.

So conceived, evaluation activity displays several fundamental characteristics: First, it is *situated or embedded*—a matter of specific people in distinct settings at particular times struggling to reach an understanding (an interpretation) of the value of their actions (taken or about to be taken). It is a matter of responsiveness—'being with' or in relation to the activities one evaluates.

Second, evaluation is thus a kind of *accomplishment;* it is something that is continuously carried out (and not something simply achieved) like parenting, teaching, counseling, and so on. It is corporeal and takes up ways of acting—gestures, demeanor, style, habituations, recognition, intimacy (or the lack thereof), and so on.

Third, this accomplishment is a *lived reality* and thus it is marked by disorder, playfulness, spontaneity, disagreement, ambiguity, uncertainty, situational specificity, contingency, a good deal of (some might say, endless) criticism, and often something like radical diversity of views about what is the right thing to do or whether one has done the right thing well.

Fourth, evaluation is *performed* in the sense that the evaluation decisions that rehabilitation professionals and

municipal officials make (about what it is right to do) are not simply intellectual choices but embodied conditions—decisions taken make, in part, who and what the decision makers are. The lived reality of determining the merit, worth, or significance of our human actions reveals it to be a self-constitutive activity.

Fifth, evaluation is *dialogical*, but in a special sense of that word. The dialogue that transpires among stakeholders and between stakeholders and the evaluator is not a neutral communicative procedure concerned only with deliberating rival claims. Dialogue in evaluation is typically presented as a deliberative procedure concerned with a search for knowledge, understanding, and (ideally at least) agreement. In the way of thinking about evaluation presented here, dialogue is not regarded as means to "domesticate difference," that is, to regarding differences simply as variations in (diverse) viewpoints that are potentially reconcilable through deliberation (Burbules and Bruce, 2001). Rather, dialogue is regarded as embracing differences, even those that resist accommodation or assimilation into an agreement, and is understood as a situated practice (not a neutral procedure) implicated by the particulars of who, what, where, when, and how the dialogue takes place. Dialogue in evaluation is thus a moral-practical encounter of embodied agents not just of ideas or points of view.

In this kind of dialogue, all parties in the ecology of rehabilitation praxis—professionals, disabled individuals and their families, and municipal officials—must learn that dialogue proceeds pedagogically and has the aim of understanding self and other, rather than unfolding technically as a method for resolving difference. Dialogue is a situated practice that can have several kinds of outcomes including: (a) not agreement, but a common understanding in which parties do not agree but establish common meanings in which to discuss their differences; (b) not a common understanding, but an understanding of differences in which the parties do not entirely bridge these differences, but through analogies of experience or other indirect translations can understand, at least in part, each other's position; (c) little understanding, but a respect across differences, in which parties do not fully understand one another, but by each seeing that the other has a thoughtful, conscientious position, they can come to appreciate and respect even positions they disagree with. This idea of an evaluation "dialogue across differences" embraces difference, diversity, and the messiness of human life rather than seeking to resolve it (Burbules and Rice, 1991).

Understood in this way, the very reality of evaluation—its significance as a human undertaking—is grasped not in the application of some procedure or method to determine the effectiveness of a treatment, nor in distanced, abstract

contemplation of the properties and behavior of some evaluand—some object-like entity such as a program or a project—but in its very enactment as a moral-political practice. Evaluation is a performative activity; what it means unfolds in its very doing or actualization. This doing is invariably marked by ambiguity, contingency, circumstantiality, and always-contested ways of what it means to do the right thing.

Evaluation here means learning to struggle with questions of value rationality: Where am I (are we) going? Is this desirable? What should be done? Who gains or loses by this action? (Flyvbjerg, 2001). Or, we might say the fundamental evaluative questions here are: What is it right to do and good to be in this situation? These questions are not answerable in terms of means-to-end thinking, but require a kind of thinking and acting that are inseparable from being. They require knowledge of the kind Aristotle called *phronesis* (wise judgment). Therefore, evaluation is less a deliberative human enterprise concerned with acquiring knowledge for the purpose of having power and control, and more like a process that happens to human beings—an event in which we must learn to participate, not a tool we must learn to apply. Evaluation is not a process in which we are in control of means to an end, but a process which itself achieves our sense of ourselves as individuals (and a society) of a particular kind. We are always "put in the way" of evaluation experiences. We always already find ourselves in a process of valuing, of deciding whether we are doing the right thing and doing it well.

In facing this situation, the individual (or the group), must learn to embrace the lived reality of diverse, contested, messy evaluative decision-making. The assumption is that there is inherent, inescapable, fundamental ambiguity, diversity, and uncertainty in life. The first move here is to welcome and profoundly respect this state of affairs (including social differences, local traditions, professional obligations, and so forth) instead of working so hard to overcome, eradicate, or control these facets of every day life. At issue here is not simply the liberal tolerance of or deference toward diverse points of view, but the idea of welcoming the very idea of difference.

This way of thinking about the activity of evaluation also requires owning up to the moral and political accountability of our decisions and actions. Instrumentalist conceptions of evaluation as a means to an end encourage us to mistake technical proficiency for moral responsibility. When evaluation is conceived instrumentally, all the problems we face in deciding about how to deal with questions of what should be done (which is the central problem of providing the 'right' rehabilitation services) are regarded as technical problems that can be solved either by acquiring special knowledge that we

lack or a special method or procedure of which we are unaware or only poorly follow or execute.

However, efforts to enhance practitioners' ability to manage and control their practice, over time, alienate them from the responsibility that inevitably befalls them for the moral-practical decisions they must make. When evaluation activity is conceived solely as a means to an end, practitioners are not encouraged to personally grapple with the inherent ambiguity, the diversity of opinion, and the contingencies that characterize everyday life as they, either individually or collectively, attempt to make the right evaluative decision at this time, in this place, under these circumstances, facing this particular person. They are not encouraged to accept responsibility for their decisions in the face of the inherent ambiguity of moral-political life. They are not invited to embrace and dwell in the divergence of views as an opportunity for self-transformation and new understanding, but to reach for knowledge and procedures that will assist them in eliminating their confusion and the ambiguity and diversity of views that characterize the situation in which they find themselves. In sum, when evaluation is cast in exclusively instrumentalist terms, then individuals are led to frame the evaluative decisions they face as technical problems to be solved. They are encouraged to think that what is at issue is whether they have either the right knowledge or procedure at hand so that they can clear up errors in their faulty reasoning.

New Focusing Questions for Evaluation

As noted above, the sole focusing question of a treatment-effects model of evaluation is the outcome of functional improvement—the primary issue is the efficacy of treatment. It should be apparent that although communities of rehabilitation professionals cannot ignore this question, evaluation of the ecology of rehabilitation praxis requires attending to at least three other central questions:

- In what ways are new work models being developed in communities of rehabilitation professionals?
- How are members of these communities developing a sense of mutual engagement around these new models?
- What new routines, sensibilities, vocabularies, and so on are being developed to support these new models?
- How is the issue of the ethics of relation (including notions of professional obligations and responsibilities, citizen rights, and state responsibilities) being discussed in the development of communities of rehabilitation practice?
- How are issues of the independence and interdependence of citizens fostered in the actions of these communities?

Responsibilities of Stakeholders in an Evaluation

It is typical to regard stakeholders in an evaluation simply as sources of information that the evaluator draws upon to prepare her or his judgment of the effect of a treatment. Evaluation is regarded as the responsibility of the evaluator, and stakeholders simply await the evaluator's final report. In an evaluation approach that matches the idea of ecology of rehabilitation praxis, roles and responsibilities of people involved in an evaluation change dramatically. Most significantly, *all* participants are responsible for evaluation, albeit in different ways.

Disabled citizens seeking various kinds of rehabilitation services must realistically assess their needs, ask themselves how they will achieve the mix of independence and interdependence necessary to their self-realization, decide how they will meaningfully participate with professionals and others in the efforts to meet their needs, decide when acting up or out is more effective than acting in concert, and so on.

Officials in municipalities and county municipalities face new challenges to their role as public officials: They are now being called upon to serve rather than steer—to help citizens articulate and meet their shared interests rather than attempt to control or steer society in new directions (Denhardt and Denhardt, 2000). Municipal and county officials become responsible for contributing to the collective, shared notion of the public interest or good. They are responsible for brokering existing communities of practice, fostering the development of a new community of practice of rehabilitation professionals, and serving as catalysts for community engagement. This is fundamentally an evaluative undertaking for it requires that these officials critically reflect upon their actions and justify their choices as appropriate and effective.

Professionals in discrete communities of practice face a daunting two-fold evaluative task: First, they must look *within* their own discrete communities and ask themselves the following evaluative questions: a) How do we understand the concepts *disability* and *rehabilitation*? b) What is required for us listen to the voices of disabled people and simultaneously to foster their independence and interdependence? c) How do relations of privilege and power influence our work and our sense of responsibilities to disabled people? d) How are we complicit in reproducing disabling images, language, and discriminations? Second, they must look *outside* their own respective communities of practice to learn how others answer the same questions. Here, their responsibilities intersect with those of municipal officials responsible for brokering the dialogue between communities of practice.

Finally, *the evaluator in this process* has the three-fold responsibility of teaching this way of thinking about evaluation, facilitating the examination of value-rational questions within different stakeholder groups, and orchestrating this evaluative undertaking across these groups. The evaluator would most likely produce a case study narrative report of this activity in a particular locale. Others can then use this case study as a pedagogical aid in examining their own specific undertakings.

Conclusion

This paper is an invitation to think differently about the idea of evaluating rehabilitation. The ideas presented here preliminary and suggestive. However, there is no reason why we cannot reconstitute linguistically and practically our understandings of both evaluation and rehabilitation. Perhaps there is every reason why we should. There will always be evaluations that generate quantitative indicators on the types, extent, and functional outcomes of rehabilitation services. This way of evaluating is an indelible feature of professional practice in late modernity. This paper is not a call to abandon such ways of evaluating; rather it is a plea to place them in a perspective that more fully takes up the complex ways of experiencing evaluative questions in rehabilitation praxis. If the ultimate goal of evaluation is to improve services by helping us think more carefully and critically about the ends and means of what we do in the name of rehabilitation, then statistical information alone will hardly be adequate for this task. We need a way of thinking about evaluation that locates this activity centrally in everyday life and communities of praxis and that helps all of us to develop the capacity to reflect on whether we are doing the right thing and doing it well. Of course, as self-interpreting beings, we must face the reality that this is a task that never ends and a responsibility that we cannot escape.

Notes

[1] The terms *praxis* and *practice* are often used interchangeably. But the two terms carry quite different meaning. The significance of the modern use of the word *practice* is typically determined by its connotations in connection with the application of theory and science to everyday life. In contemporary definitions, theory is the realm of thinking or reflecting and practice is the realm of doing or acting. Theory and practice are defined oppositionally, and practice is everything that theory is not. Thus, we hear talk of evaluation theory as something different than evaluation practice, or a theory of teaching as opposed to the practice of teaching. The Greek term *praxis* (although used in several different ways by Aristotle), however, is not related to a theory-practice distinction. *Praxis* is a distinct type of human activity concerned with our moral-practical-political behavior and it is distinguishable from that kind of activity called *poiesis* that is concerned with our ways of making or crafting a product or outcome.

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