

Toward relationship-centred care: patient-physiotherapist interaction in private practice

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Abstract

Interacting with patients is integral to the practice of physiotherapy. Notably, however, empirically derived knowledge about how physiotherapists interact with their patients is limited, particularly in the private practice setting. In addition, heavily promoted approaches for interacting with patients, such as patient-centred care and the biopsychosocial approach, have been adopted from the medical profession, are not derived from research evidence, and therefore may not adequately reflect how physiotherapists interact with patients in physiotherapy practice. Thus, this qualitative research had two aims: first, to detail how patients and physiotherapists interact in private practice; second, to consider how the research findings related to promoted healthcare interaction approaches.

Methodologically, the research incorporated features of both ethnography and grounded theory. Observations of 52 consultations, as well as in-depth interviews with 9 patient and 9 physiotherapist participants, were undertaken. Data comprised field notes and audio-recordings of observations and interviews, and were analyzed iteratively using principles of thematic analysis and grounded theory.

The data analysis yielded two central and complementary themes. The theme 'physiotherapist-led communication' encapsulates how physiotherapists directed the style and content of communication to achieve clinical goals by providing structure, making decisions, and focussing on biomedical aspects. The second theme, 'adapting to build rapport', describes how physiotherapists incorporated adaptive communication such as eye contact, body language, touch, casual conversation, and humour into their interactions with patients. These adaptations were often intuitively enacted, were responsive to individual patient characteristics, and functioned to build rapport.

The findings neither clearly correlated to features of patient-centred care nor to the biopsychosocial approach. Rather, the findings portrayed a dynamic integration of clinical and responsive communication that fostered the development of a trusting relationship between patient and physiotherapist. These results extend knowledge of interactions in physiotherapy by providing detailed descriptions of interactional elements that incorporated patient and physiotherapist perspectives. Furthermore, the findings explain how rapport was developed between patient and physiotherapist with trust as an underlying construct. Relationship-centred care and relational notions of trust are discussed as alternative explanations for how patients and physiotherapists interact in private practice. These findings and explanations have the potential to benefit educators, physiotherapists and, by extension, patients, by offering a framework for education and the practice of patient-physiotherapist interactions.

Declaration

This is to certify that:

- (i) the thesis comprises only my original work towards the PhD except where indicated in the Preface;
- (ii) due acknowledgement has been made in the text to all other material used; and
- (iii) the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies, and appendices.

A handwritten signature in black ink, appearing to read 'Amy Hiller'. The signature is written in a cursive style with a large, looping 'y' and 'l'.

Signed: Amy Hiller Date: 3rd January, 2017

Preface

During my candidature I was supported by an Australian Government Research Training Program Scholarship.

'Table 1' in the thesis is an adaptation of 'Table 1' from my publication: 'Exploring healthcare communication models in private physiotherapy practice' in *Patient Education and Counseling* journal, Volume 98, Issue 10, pp. 1222-1228.

Two articles discussing findings related to my research have been accepted for publication in peer-reviewed journals. I include the author-accepted versions of these articles as Appendices A and B. The first publication reports initial findings from my research and was largely written by me, in collaboration with my two supervisors. The second article is a commentary on aspects of the research process, and was written in equal collaboration with a colleague, Danya Vears. Throughout my candidature, I also presented at a number of national and international conferences and seminars.

Publications

- Hiller, A.,** Guillemin, M., & Delany, C. (2015). Exploring healthcare communication models in private physiotherapy practice. *Patient Education and Counseling*, 98(10), 1222-1228.
- Hiller, A. J.,** & Vears, D. F. (2016). Reflexivity and the clinician-researcher: managing participant misconceptions. *Qualitative Research Journal*, 16(1), 13-25.

Oral Presentations

- Hiller, A.** (2012). *Is there a need for a physiotherapy-specific communication model?* Paper presented at the Communicating Health Symposium, Melbourne, Australia.

- Hiller, A.** (2013). *Considering the role of communication models in client-professional encounters: a physiotherapy perspective*. Paper presented at the Communication, Medicine and Ethics (COMET) Conference, Melbourne, Australia.
- Hiller, A.** (2013). *An examination of the patient-physiotherapist interaction in private practice*. Paper presented at the Australian Physiotherapy Association (APA) Conference, Melbourne, Australia.
- Hiller, A.** (2014). *Patient-centred care in clinical practice: an Australian physiotherapy perspective*. Seminar presented at Jonkoping University. September 2014, Jonkoping, Sweden.
- Hiller, A., Delany, C. & Guillemin, M.** (2014). *Are theoretical models of health care communication applicable in the physiotherapy setting?* Paper presented at the European Association for Communication in Healthcare (EACH) International Conference on Communication in Healthcare, Amsterdam, The Netherlands.
- Hiller, A., Delany, C. & Guillemin, M.** (2014). *The communicative power of touch in the patient-physiotherapist interaction*. Paper presented at the European Association for Communication in Healthcare (EACH) International Conference on Communication in Healthcare, Amsterdam, The Netherlands.
- Vears, D. & **Hiller, A.** (2015). *Reflexivity and the clinician-researcher: managing participant misconceptions in qualitative research*. Paper presented at the 2015 Qualitative Methods (QM) Conference, Melbourne, Australia.
- Hiller, A., Delany, C. & Guillemin, M.** (2015). *Exploring the applicability of healthcare communication theories in private physiotherapy practice: implications for teaching communication*. Paper presented at the World Confederation for Physical Therapy (WCPT) Congress. May 2015, Singapore.
- Hiller, A.** (2015). *Insider research: reflexivity as a tool to manage participant misconceptions*. Paper presented at the Australian Physiotherapy Association (APA) Conference, Gold Coast, Australia.
- Hiller, A.** (2015). *Developing trust with elderly and chronic pain populations through communication*. Invited presentation at the Australian Physiotherapy Association (APA) Conference, Gold Coast, Australia.

Poster Presentations

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I also acknowledge members of my advisory committee for their insights during our yearly meetings and A/Prof Robyn Woodward-Kron, who provided valued external guidance. Other graduate research students shaped my PhD experience and to all of them I am very grateful, none more so than Danya Vears, who has been a treasured companion and source of inspiration throughout my journey.

In addition, I extend my gratitude to the patients and physiotherapists who participated in this project. Their willingness to allow me to experience the interaction from their perspectives was the key to the success of the research.

Finally, I thank my family and close friends. Each of them has contributed love and encouragement in order for me to complete this challenging project. In particular, my mother has been steadfast in her domestic support and baby-sitting duties. To her I will be forever grateful. My mother-in-law, Diana, has offered a listening ear and extensive advice. When all others had given up asking how 'it' was going, I cherished her continued interest.

To my husband, Jonathan, I am appreciative of your belief, patience, and love. You have quietly sacrificed more than any husband should have to sacrifice in order for me to achieve this goal. I thank you.

For Zoe

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Chapter one: Introduction

Interactions between patients and physiotherapists are central to clinical practice. As a practising physiotherapist, I appreciated the importance of the interactional aspects of physiotherapy and sought to further develop my understanding through this research. I begin this introduction by discussing my interest in the area. I then define 'interaction', explaining how interaction is integral to physiotherapy practice, before examining physiotherapy as a profession, with particular reference to the private practice setting. The research aims, involving an exploration of how patients and physiotherapists interact in private practice, are articulated along with the argument and significance of this enquiry. I conclude the chapter with a thesis outline that explains the content and purpose of each of the seven chapters.

My story

Five years ago, as a motivated physiotherapist working in private practice, my experience of physiotherapy as a profession was that of a discipline focussed on evidence-based practice, structured clinical-reasoning, objective measures, rigorous assessments, and repeatable treatments. This perception was shaped by extensive professional development training courses and the clinical masters programme that I undertook to develop my expertise. Such clinical training led me to believe that expert physiotherapists were able to objectify all aspects of their practice and thus ensure that their treatments were effective and each patient made positive progress. Upon reflection, although I had been taught the ideals of patient-centredness and ethical aspects of practice, these were subsequently lost in the overwhelming drive for knowledge and skills in treating the physical body. Derived largely from the content and focus of my clinical masters training, I came to believe that the essence of physiotherapy lay in knowledge about, and implementation of, clinical skills involving sound manual therapies and specific exercise programmes.

While working clinically as a physiotherapist in private practice, I tried to perform these structured and objective assessments and treatments with patients and often felt uncomfortable. For me, there was a mismatch between my learned perceptions of the ideal practice of physiotherapy and my understandings of how to relate to patients as individual people. Something was missing in my consultations with patients and this unsettled me. I gradually allowed myself to practise the way that I felt comfortable practising, letting my human values guide me. My impetus for evidence-based objectivity lessened, I became more relaxed and attentive towards my patients, and patients seemed to respond by becoming more engaged in our combined physiotherapeutic goals. Thus, seemingly without compromising patient outcomes, I gathered anecdotal evidence that the way I interacted with my patients had influenced how both I, and my patients, experienced physiotherapy.

This understanding sparked my interest in what some might term the 'non-clinical' aspects of practising physiotherapy. As I thought about what it was that I enjoyed and valued about being a physiotherapist, I centred on the relational aspects of practice; how my patients and I communicated with each other became a priority. I enjoyed hearing snippets of patients' lives, sharing experiences, and the challenge of considering how I could adjust and adapt my treatments to suit their individual needs. Through this journey I retained professional objectivity and continued to learn, respect, and appreciate the evidence for physical interventional aspects of physiotherapy. I sensed, however, that this evidence needed to be balanced with evidence for the potentially neglected interactional, ethical, and value based aspects of practice.

I started to explore the research evidence and clinical guidelines for interacting with patients and was surprised by the paucity of literature in this area. Many sources suggested I should be patient-centred, but when I tried to follow the descriptions I discovered that it was not sufficiently clear how I should implement this approach in practice. An undergraduate physiotherapy student

once said to me: 'I feel like we are told over and over to be patient-centred and in theory it makes sense, but I don't really know how to do that when I'm actually treating patients'. Her comment resonated with my own experiences and I felt inadequate as I tried to explain it to her. I was aware that this interactional aspect of practice was significant, yet I was unable to describe or explain it. In my experience, the theory about interacting with patients promoted in physiotherapy education programmes seemed to be lacking a practical dimension.

This thesis therefore details the formal exploration that followed my initial musings about interaction. I sought to generate knowledge about interacting with patients in physiotherapy, with a particular interest in how they were negotiating the challenge of combining their clinical tasks with the human aspects of caring for each individual patient. I also wanted to consider whether the currently espoused theories such as patient-centred care and the biopsychosocial approach were being applied in practice.

Hence, the thesis is largely related to the theory-practice juxtaposition in the field of interaction in physiotherapy. Adopting the premise that practice and theory should align, and that theory should represent and frame practice (Vansteenkiste & Sheldon, 2006), my research was an attempt to develop theoretical knowledge derived from practice. I aspired to generate a conceptual framework to help myself and other physiotherapists to learn how physiotherapists currently interact, implement communication skills, and attend to the needs of each patient. In developing a conceptual framework I also aimed to provide the language and specifics for teaching and reflecting upon interaction as an important aspect of physiotherapy clinical practice.

My project is an inductive investigation to reflect the exploratory nature of my enquiry. The research was designed to answer the question: 'how do patients and physiotherapists interact with each other in the private practice setting?'

Throughout this thesis I have chosen to use the term ‘patients’¹ for two reasons: first, to acknowledge that the research is about a healthcare interaction, which is a distinctive type of human interaction (Tallis, 1999), and second, because research has shown that seekers of healthcare generally prefer this term over other options (Deber, Kraetschmer, Urowitz, & Sharpe, 2005; Lloyd et al., 2001; Nair, 1998; Wing, 1997). To answer my research question comprehensively my methods involved observing interactions between patients and physiotherapists, and interviewing both patient and physiotherapist participants about their experiences.

In undertaking this research I needed to describe and define interaction in the physiotherapy setting and understand relevant aspects of the nature of the physiotherapy profession.

Interaction in physiotherapy

In this section I clarify the ‘patient-physiotherapist interaction’ and justify reasons why I chose to research interaction in physiotherapy beyond my intuitive sense that it was important. I first define interaction and, in so doing, illustrate the lack of clarity in terminology throughout healthcare. Second, I establish the centrality of interaction to the practice of physiotherapy. Third, I identify the significant gaps in research knowledge about interaction in physiotherapy that this research sought to address.

Defining interaction

In healthcare and physiotherapy literature, the encounter or exchange occurring between patient and practitioner is commonly referred to as patient-practitioner communication or patient-practitioner interaction (for example, Allegretti,

¹ I acknowledge that the terms ‘client’ and ‘patient’ are both used in physiotherapy literature, and that there is considerable debate about the appropriate term to describe those who seek health services (Deber et al., 2005).

Borkan, Reis, & Griffiths, 2010; Booth, LeCouteur, & Chur-Hansen, 2013; Chester, Robinson, & Roberts, 2014; Grady, Carey, Bryant, Sanson-Fisher, & Hobden, 2017; Mast, 2007; Pilnick, Hindmarsh, & Gill, 2009). In addition, another related and commonly used phrase is the patient-practitioner relationship (for example, Cobos, Haskard-Zolnierrek, & Howard, 2015; Conboy et al., 2010; Rees, Ajjawi, & Monrouxe, 2013). Thus, 'interaction', 'communication', and 'relationship' are three words often used to describe the exchange or encounter between patient and practitioner. Authors in nursing, who undertook a review of the concepts of nurse-patient communication and nurse-patient interaction, concluded that these terms were used synonymously and that clear definitions of the terms were usually avoided or were implicit (Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009). It is therefore likely that there is significant overlap between the meanings and use of the terms interaction, communication, and relationship when applied to the one-on-one encounter between patient and practitioner.

Because of its nature, the one-on-one exchange between patient and physiotherapist explored in this research is considered interpersonal (Bylund, Peterson, & Cameron, 2012). Three dimensions of interpersonal encounters have been specified: the state of mind of each individual, communication exchanged between the two, and the relationship that forms between the two (Baxter & Braithwaite, 2008). According to these characterizations of the dynamics of interpersonal encounters, the communication and the relationship between the two people involved are subsidiaries of the entire interpersonal exchange. In this research I therefore consider that the communication and the relationship are both constituents of interpersonal interaction.

Communication is defined as the 'imparting or exchanging of information' via a medium (Oxford Dictionaries, 2016). This description suggests that communication does not necessarily have an impact on another person and can be unidirectional. For this reason, communication is inadequate as a term to define the entirety of the encounter between patient and physiotherapist.

Interaction, in contrast, is defined as ‘reciprocal action or influence’ (Oxford Dictionaries, 2016) and therefore acknowledges the reciprocal nature of the exchange and the influence on the other. As a term, relationship differs again because it centres upon ‘the way in which the two people are connected’ (Oxford Dictionaries, 2016). Communication provides the basis for the relationship. Hence, all three of these terms are entwined and each can impact upon the other. It is likely that this is why physiotherapy and healthcare literature has tended to use these terms interchangeably.

For the purpose of this research, I use ‘interaction’ as the term to capture the entirety of the encounter between patients and physiotherapists.

‘Communication’ is used to describe specific elements or types of information exchange that occur in patient-physiotherapist interaction. These include verbal and non-verbal elements of communication ranging from words used, speech tone, and speech volume, to body language, eye contact, and touch. Finally, I use ‘relationship’ to describe the nature of the connection between patients and physiotherapists.

Interaction as integral to the practice of physiotherapy

Interaction has been identified as integral to physiotherapy practice (Higgs, Refshauge, & Ellis, 2001). The ‘Policy Statement: Description of Physical Therapy’ made by the World Confederation for Physical Therapy² (2011) states:

An integral part of physical therapy is interaction between the physical therapist and the patient/client/family or caregiver to develop a mutual understanding. This kind of interaction is necessary to change positively the body awareness and movement behaviours that may promote health and wellbeing. (p. 4)

² The World Confederation for Physical Therapy is hereafter referred to as WCPT.

This statement highlights that the practice of physiotherapy necessitates patient involvement in changing movement behaviours, and that a mutual understanding developed through interaction is a means to achieve this. In addition to the 'Description of Physical Therapy', codes of conduct and physiotherapy literature confirm the centrality of interaction and communication to the practice of physiotherapy (for example, Physiotherapy Board of Australia, 2014; Harman, Bassett, Fenety, & Hoens, 2011; Roberts & Bucksey, 2007; Williams & Harrison, 1999). Extending the importance of interaction, some authors contend that interaction or communication in the physiotherapy setting is therapeutic in itself, and has the potential to influence patients' experiences of pain, improve patient self-efficacy and adherence to exercises, and impact physical function (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010; Jeffels & Foster, 2003; Klaber Moffett & Richardson, 1997). Thus, interaction is central to the practice of physiotherapy because it can positively influence treatment outcomes, and also because it is the necessary means to perform clinical tasks, achieve practice goals, and shape the alliance between patient and physiotherapist.

Knowledge about interaction in physiotherapy

Given that interaction is fundamental to physiotherapy practice, it is surprising how little research has focussed specifically on interaction or communication in physiotherapy. This is particularly apparent when one compares the small body of research about interactional aspects with the plethora of research about clinical interventions in physiotherapy. A number of authors in the field have specified the requirement for empirically derived knowledge about interaction in physiotherapy (Opsommer & Schoeb, 2014; Parry & Brown, 2009; Roberts & Bucksey, 2007).

In Chapter two I provide a detailed review of the current literature that presents knowledge about aspects of interaction in physiotherapy and in so doing reveal

the little that is known about interaction in the private practice setting. I also explain that much of the current knowledge is derived from focus group and interview studies that reflect physiotherapist or patient perspectives of interaction. In addition, I present the observational research into what occurs in interactional practice, demonstrating how this literature largely explores aspects of interaction as silos of knowledge. In Chapter two I therefore justify my choice to situate my research exploration in the private practice setting, and to primarily use observational research supplemented by patient and physiotherapist interviews to ascertain detail about the entirety of interactional practice between patients and physiotherapists.

To situate interaction in physiotherapy, I now describe the physiotherapy context.

The physiotherapy context

To conceptualize the nature of interactions occurring in physiotherapy practice, in this section I explain what physiotherapy is, the central goals of physiotherapy practice, and the philosophical frameworks that inform the profession. I also introduce some approaches to interaction espoused in physiotherapy, and give justifications for my questions regarding the theoretical support for interaction in physiotherapy. This section concludes with a description of the Australian healthcare system and the physiotherapy private practice setting to provide a context for the interactions specifically incorporated into this research.

The physiotherapy profession

Physiotherapy or physical therapy³ is a healthcare profession that ‘provides services to individuals and populations to develop, maintain, and restore maximum movement and functional ability throughout the lifespan’ (WCPT, 2011, p. 1). Physiotherapy emerged as a discrete profession from therapies concentrating on massage (McMeeken, 2014). Traditionally, physiotherapists have therefore incorporated manual therapies to restore and maximize movement as part of their practice. Physiotherapists do this by reducing pain, improving muscle strength and motor control, improving balance and flexibility, and enhancing general activity and cardiovascular fitness (Higgs et al., 2001). Non-invasive, active therapies such as motor skill retraining, exercise therapy, massage, joint mobilization and manipulation, and hydrotherapy are included in physiotherapy’s scope of practice, and are commonly used to achieve the goals of physiotherapy treatment (Higgs et al., 2001). This means that touch and close physical proximity are often predominant features when physiotherapists are interacting with patients. In addition, both parties are usually actively involved in movements and exercises. These specifics of interactions in physiotherapy are detailed in Chapter two.

As a profession, physiotherapy is an occupational group of highly trained, committed individuals who have professional autonomy, a recognized knowledge base and therapeutic role, and the means of maintaining professional standards (Higgs, Hummell, & Roe-Shaw, 2009; Popkewitz, 1994; Richardson, 1999). In Australia, physiotherapists must be registered and have their practice regulated by the Australian Health Practitioner Regulation Agency (Physiotherapy Board of Australia, 2014). Australian physiotherapists are considered autonomous first contact practitioners, meaning that patients do not require a medical referral to visit a physiotherapist (Struber, 2003). Professions

³ Physical therapy is the American title for physiotherapy. Physiotherapy and physical therapy are equivalent terms for the same profession. I use the Australian terminology of ‘physiotherapy’ but the terms can be used interchangeably.

are afforded considerable status in the community, and are therefore required to maintain particular standards of practice. One key aspect of professionalism is for practice to be evidence-based. Physiotherapy requires research evidence to uphold the knowledge base and appropriate educational processes that ensure that physiotherapists have the knowledge and training to maintain the standards of the profession. However, with regard to interaction this required evidence is lacking. A need for evidential knowledge to support professional standards is a further reason why my research exploration of interaction is important for the practice of physiotherapy.

Theory in physiotherapy

As a profession, physiotherapy values theories that support and inform physiotherapy practice and education. Relevant physiotherapy specific knowledge is based upon biological, physical, and clinical sciences (Health & Care Professions Council, 2013). In addition, evidence-based practice, clinical reasoning, patient-centred care, and the biopsychosocial approach are frequently stated as guiding frameworks in professional documents, and throughout the physiotherapy literature (for example, Cruz, Moore, & Cross, 2012; Edwards, Jones, Carr, Braunack-Mayer, & Jensen, 2004; Health & Care Professions Council, 2013; Jones, Edwards, & Gifford, 2002; Jones, Jensen, & Edwards, 2008; Physiotherapy Board of Australia, 2014; Sanders, Foster, Bishop, & Ong, 2013; Struber, 2003). The practice of physiotherapy is also supported by ethical and professional guidelines (Higgs et al., 2001). Each of these guiding frameworks support the professionalization of physiotherapy. Such philosophical underpinnings demonstrate that as a profession, physiotherapy values theories that inform and guide practice.

However, such frameworks as evidence-based practice (Bouffard & Reid, 2012), patient-centred care (May & Mead, 1999), and the biopsychosocial approach (Engel, 1978) were originally described for the medical profession, and have

been adopted and extrapolated to physiotherapy. It is therefore possible that some of the features of these approaches may not be applicable in the physiotherapy context. Unless they are considered in relation to physiotherapy practice and redefined specifically for the physiotherapy profession, the relevance of these approaches in physiotherapy can be questioned.

In contrast, clinical reasoning frameworks were developed from empirical research that explored how experienced physiotherapists reasoned their clinical decisions during interactions with patients (Edwards, 2000; Edwards et al., 2004). Probably because of its research and physiotherapy-specific origins, clinical reasoning theory is highly regarded as a significant aspect of physiotherapy practice (Smith, Ajjawi, & Jones, 2009). As such, aspects of the physiotherapy clinical reasoning framework have been further developed through research (Ajjawi & Higgs, 2012; Langridge, Roberts, & Pope, 2015), and studies have demonstrated clinical reasoning to be actively employed by physiotherapists during consultations with patients (Cruz et al., 2012; Josephson, Bülow, & Hedberg, 2011). The widespread integration of the physiotherapy-specific clinical reasoning framework is an example of the practical implementation of a theory derived from empirical research, and highlights the value of theory to the physiotherapy profession.

Acknowledging that theory is valued in physiotherapy, and that interaction is integral to physiotherapy practice, it is surprising that a physiotherapy-specific interaction theory is lacking. The biopsychosocial and patient-centred care approaches are advanced as theories for physiotherapists to use when interacting with patients (Cooper, Smith, & Hancock, 2008; Jones et al., 2002; Sanders et al., 2013). However, many questions surrounding the descriptions, relevance, and interpretations of patient-centred and biopsychosocial approaches remain, and I outline these in Chapter two. These questions provide a rationale for my enquiry into whether these approaches are appropriate as theoretical constructs to support interaction in physiotherapy. Other

approaches, in particular an emancipatory or critical social science approach (Trede, 2006, 2012; Trede, Higgs, Jones, & Edwards, 2003), have been suggested as appropriate for physiotherapy interactions, but are not perceived to be embedded in physiotherapy practice (Trede, 2006).

Physiotherapy in the Australian healthcare context

The Australian healthcare system has been described as a complex 'web' with many inter-related services, providers, and organizational structures (Australian Institute of Health and Welfare, 2017). Healthcare services are usually provided in either primary healthcare settings, such as community health and dental clinics, or hospital settings, of which the majority are public, with some private hospitals (Australian Institute of Health and Welfare, 2017). Healthcare in Australia is mostly government funded but there is a significant private sector. The Australian government fund Medicare, the universal public health insurance scheme, to allow free or subsidized treatment for all Australians (Australian Institute of Health and Welfare, 2017; Budget Direct, 2015). In addition, Australian citizens can pay to have private health insurance, which, depending on the level of cover, provides reimbursement or partial reimbursement of healthcare fees and access to private hospitals (Budget Direct, 2015).

Most commonly, general practitioners in the primary health setting are the first contact point (Australian Institute of Health and Welfare, 2017). General practitioners usually provide referrals to other healthcare providers and services as required. Registered physiotherapists in Australia sometimes receive referrals from general practitioners but are also considered autonomous first contact practitioners as part of primary healthcare. This means that physiotherapists have the ability to act independently of medical referrals. Patients wishing to see physiotherapists who work in either in- or out-patient hospital or community settings, however, require a medical referral to access these services that are provided at no cost to the patient.

Physiotherapy private practice

Physiotherapists working in private practice, in contrast to those in a hospital or community setting, mostly consult patients who have made an appointment independently, without a referral. Private practice physiotherapy is generally funded by the patients themselves, often with support from their private health insurance (Struber, 2003). Private practice physiotherapy is also often funded by third party insurers, such as worker's compensation insurance companies and the Transport Accident Commission, which fund treatment for work-related injuries and injuries as a result of car accidents, respectively (Transport Accident Commission, 2014; Understand Insurance, 2017). In addition, with the support of a patient management plan from a general practitioner, the government Medicare scheme funds a limited number of consultations with a private physiotherapist for those with conditions that are considered chronic.

Private practice is the predominant workplace option for physiotherapists in many countries including Australia, Canada, and Denmark (Hudon, Drolet, & Williams-Jones, 2015; Praestegaard, Gard, & Glasdam, 2013; Service and Workforce Planning, 2006). The private practice setting shares similar characteristics to hospital outpatient clinics where patients attend from home for a time-specific appointment with a physiotherapist. Patients have the choice about where and when to attend private physiotherapy, and do not require a referral from a doctor or other health professional. Interactions in private practice generally occur between a patient and a physiotherapist within a contained space, usually a room or a cubicle with curtaining. Each patient interaction is part of a physiotherapist's schedule for the day and is allocated a specific amount of time, most commonly between 20 and 30 minutes.

Physiotherapy is a diverse profession with physiotherapists working with patients in a variety of different settings and contexts. In addition to private practice, workplace settings for physiotherapists include acute and rehabilitation

hospitals, community health centres, fitness centres, and domiciliary care services (Service and Workforce Planning, 2006). Although the choice to limit this research to the private practice setting has relevance to the many physiotherapists working in private practice, I recognize that this choice reduces the applicability of findings to other settings. It is possible that the nature of interactions between patients and physiotherapists in hospital and group settings would be different, possibly due to diversity in physiotherapy treatment aims and the numerous people involved in each patient's care.

Compared with hospital and community settings, the private practice setting brings added business and financial considerations that create ethical issues for physiotherapists (Hudon et al., 2015; Praestegaard et al., 2013). Private physiotherapy practice is a business with a for-profit nature where physiotherapists are often remunerated according to the number of patients they see per day (Hudon et al., 2015). Consequently, physiotherapists in private practice have considerable time pressures because they are trying to see more patients (Hudon et al., 2015). These considerations, specific to private practice, are likely to both challenge and impact on how physiotherapists interact with patients.

I chose private practice as the context for this research for three reasons. First, it is the main practice setting for physiotherapists in Victoria, Australia (Service and Workforce Planning, 2006). Second, due to business features and time restraints, it could be considered a particularly challenging environment in which physiotherapists interact with their patients. Third, as I establish in Chapter two, there is limited research into the interaction between patients and physiotherapists in private practice. Thus, my results: are relevant to a large proportion of physiotherapists working in Victoria, Australia; add to the minimal evidence about patient-physiotherapist interactions in private practice; and build an understanding of how physiotherapists interact with their patients in a

context that is particularly demanding. Such understanding is necessary for development of theory and as a platform for future research.

Having detailed the research context regarding interaction and physiotherapy, I go on to detail the aims and significance of the research including a statement of the thesis argument.

Aims and scope of the thesis

Research aims

My project had two aims. The first was to describe patient-physiotherapist interactions in the private practice setting. I sought to address pertinent gaps of knowledge about interaction in physiotherapy by providing holistic descriptive representations of interactions occurring between patients and physiotherapists in private practice. The second aim was to compare my empirical findings with promoted approaches to healthcare interaction, such as patient-centred care and the biopsychosocial approach, and consider whether these approaches are relevant to, and representative of, patient-physiotherapist interactions in the private practice setting. The second aim arose from the belief that theory is important to professional practice and, in this instance, is justified by the small body of literature that suggests there may be a theory practice-gap with regard to interaction in physiotherapy (Cruz et al., 2012; Josephson, Woodward-Kron, Delany, & Hiller, 2015; Opsommer & Schoeb, 2014). Overall, my research endeavoured to study both practice and theory of interactions between patients and physiotherapists in private practice.

Thesis argument

My research findings are presented as two themes that portray how interactions between patient and physiotherapist incorporate and integrate two broad and

encompassing dimensions of interaction: 'physiotherapist-led communication' and 'adapting to build rapport'. My findings demonstrated that physiotherapists led and directed interactions by initiating questions, making decisions, and incorporating predominantly biomedical content to assist them to achieve clinical tasks. This physiotherapist-led communication was coupled with adaptive communication that was responsive to the needs of the individual patient and functioned to build rapport. Notably, adaptive communication was mostly non-verbal, and included dynamically adjusting body language, eye contact, and touch for each individual patient. The data analysis indicated that elements of communication from both themes were specifically incorporated in a complementary way to achieve the purposes of the interaction: to provide physiotherapeutic clinical treatment and to care for the patient. In so doing these communicative elements also fostered a trusting therapeutic relationship.

Using my empirical findings as a comparator, I deduced that patient-centred and biopsychosocial approaches to interacting with patients are not appropriate theoretical representations of interactions in physiotherapy private practice. Patient-centredness is described as incorporating the patient's perspective (Mead & Bower, 2000) and the biopsychosocial approach emphasizes the incorporation of biomedical, psychological, and social content into the interaction (Engel, 1978). Thus, there are fundamental differences between these proposed approaches for interacting with patients and the interactions actually observed in my research. The patient-centred and biopsychosocial approaches highlight the incorporation of the patient's perspective and all aspects of the patient as being essential, whereas my findings drew attention to the relationship between patient and physiotherapist as the central feature of the interaction.

Based on these findings, I conclude that a relationship-centred approach sustained by trust is an appropriate alternative framework that better reflects the central components of interaction between patient and physiotherapist in

physiotherapy private practice. My discussion focuses on the trusting relationship between patient and physiotherapist. I use my empirical findings to explain the characteristics specific to the patient-physiotherapist relationship, particularly the functional and responsive characteristics that relate to physiotherapist-led and adaptive communication respectively. I also relate my findings to concepts of trust, and explain how the elements of interaction occurring in physiotherapy practice are used to develop and sustain relational trust in patient-physiotherapist interactions.

Significance to physiotherapists and to the physiotherapy profession

The findings of this research contribute empirical knowledge about patient-physiotherapist interactions in the private practice setting. Specifically, the results detail elements of the interaction such as structure, focussing on physical aspects and pain, touch, body language, and casual conversation as aspects of communication that are incorporated into patient-physiotherapist interactions. In accordance with my aims, I therefore provide a detailed account of the patient-physiotherapist interaction, and knowledge about how interactions with patients occur. In addition, my findings demonstrate that the purpose of physiotherapist-led communication is to achieve functional, clinical tasks, and that the purpose of adaptive communicative elements of communication is to build rapport. Furthermore, to elucidate how the patient-physiotherapist relationship and notion of trust emerged as central to interactions, my discussion incorporates my findings into previously described frameworks of relationship-centred care and trust. These theoretical explanations, particularly relationship-centred care, have the potential to provide a new direction for how the physiotherapy profession conceptualizes interactional aspects of practice.

Both my empirical findings and theoretical explanations provide detailed descriptions that have the potential to be used to educate students and physiotherapists about how to interact with patients. In addition, this practical

and empirically derived knowledge could assist practising physiotherapists to reflect on their interactions with patients and consider the purpose and types of communicative strategies that they are using in clinical practice. The research findings also provide a platform from which future research can consider specific elements of interaction in detail, or can explore the value of relationship-centred care in optimizing interactions with patients in the future.

Significance to patients of physiotherapists

My research also has significance for patients of physiotherapists. First, and foremost, by including patient interviews and considering patients' roles in the interaction, the patient perspective has been incorporated into knowledge about interactions and physiotherapists may integrate such knowledge into their clinical practice. Second, interested patients could use my findings to inform their role in interactions with physiotherapists. Finally, future patients may benefit from physiotherapists having increased knowledge and education about interacting with patients in a manner that fosters trust and centres on building and sustaining relationships.

Thesis outline

Chapter one: Introduction

The research was introduced with an outline of my personal experiences and interests in the topic. I also presented the research question, physiotherapy context, and research rationale, explained the research aims, and established the thesis argument that patients and physiotherapists interact in a trusting and relationship-centred manner.

Chapter two: A review of the practice and theory of patient-physiotherapist interaction

In Chapter two, literature about the practice and theory of interactions between patients and physiotherapists is introduced. In this review, I detail current knowledge about interactions in physiotherapy, highlighting the knowledge gaps that I sought to address with this research. In addition, I describe features that normative and general discussion literature presents as specific to physiotherapy interactions, namely, the extensive use of touch and active patient participation. The likelihood that physiotherapy interactions differ from other healthcare patient-practitioner interactions in some way highlights the need for further knowledge specifically pertaining to interactions in physiotherapy. It also justifies the necessity to consider how physiotherapy interactions occurring in practice relate to healthcare interaction approaches. Hence, Chapter two includes descriptions of established approaches to healthcare interaction that are promoted in physiotherapy and healthcare more generally. As part of these descriptions I explain further reasons why there is precedent and need to question the relevance of these approaches to the practice of patient-physiotherapist interactions, thereby justifying the second aim of my research.

Chapter three: Methods

In the methods chapter I outline the research process including epistemological perspectives, methodological frameworks, methods of data collection and analysis, and ethical considerations. The research methods were qualitative and framed within the interpretive paradigm. Methodologically, the research incorporated principles of both ethnography and grounded theory. Data collected were field notes and audio-recordings of observed patient-physiotherapist interactions and in-depth interviews with both physiotherapist and patient participants. The analysis process was iterative and incorporated thematic analysis and 'grounded theorizing' to generate elements of

communication that are captured within two themes and constitute the results of this research. Throughout the methods chapter I describe the role that I played as the researcher and my impact on the research process and findings. I discuss how I framed my identity and used reflexivity to assist me to remain attuned to ethical concerns and potential misconceptions of participants.

Chapter four: Physiotherapist-led communication

Chapter four is the first of two results chapters in which I describe one of the two central themes that were developed through analysis of all data. Although these themes are presented separately, they depict complementary styles of communication that are integrated within the patient-physiotherapist interaction.

The first theme, 'physiotherapist-led communication', presented in Chapter four, encapsulates how physiotherapists directed both the style and content of patient-physiotherapist interactions by leading a consistently structured interaction, using mostly closed-ended questions, making decisions, using biomedical language, and focussing on physical aspects and pain. These elements of interaction are detailed in three sections beginning with the observational perspective, and then including findings that represent the physiotherapist and patient perspectives. Each of these sections provides specifics from the data that substantiate physiotherapists leading the interaction in a clinical manner being an important part of patient-physiotherapist interactions in private practice. Interestingly, patients corroborated these findings by stating that they appreciated and expected the direction that physiotherapists provided. While not surprising, the specifics of these 'physiotherapist-led' findings are an important component of physiotherapy and healthcare interaction.

Chapter five: Adapting to build rapport

My second results chapter presents the second central theme developed from the data titled: 'adapting to build rapport' and also considers how the findings relate to approaches to healthcare interaction. This chapter is largely dedicated to describing the elements of interaction derived from all three data sources that explain how communication was adapted in each individual patient-physiotherapist interaction. In particular, eye contact, body language, touch, casual conversation, and humour, were incorporated and adapted in dynamic ways that fostered the development of rapport between patient and physiotherapist. In developing rapport, many of these elements of adaptive communication also contributed to establishing a trusting relationship between the patient and physiotherapist.

I end this fifth chapter with a comparison between the research findings and the features of established approaches to healthcare interaction, such as patient-centred care, outlined in Chapter two. I conclude that these promoted approaches do not capture the adaptive and responsive communication found to be central in my research, and are therefore inadequate as frameworks to explain how patients and physiotherapists interact in private practice.

Chapter six: Theorizing the patient-physiotherapist interaction in private practice

As my findings were not adequately captured by established and promoted approaches to healthcare interaction, the aim of Chapter six was to discuss other possible explanatory frameworks. Chapter six progresses knowledge presented as findings in Chapters four and five, and centres on the relationship between patient and physiotherapist as fundamental. In this chapter I explain how physiotherapist-led communication and adaptive communication were dynamically integrated in patient-physiotherapist interactions to develop a

relationship based upon trust. Relationship-centred care is proposed as an appropriate framework that captures functional, physiotherapist-led and responsive, adaptive communication within one interaction. In addition, descriptions of trust, particularly that of merit trust, are detailed in relation to the findings to extend understandings about the patient-physiotherapist relationship and explain how trust was achieved as they interacted with each other.

Chapter seven: Implications and conclusion

In the final chapter I explain how my findings, combined with explanatory frameworks of relationship-centred care and merit trust, answered the research question by providing descriptions of how patients and physiotherapists interact in private practice. Physiotherapists direct interactions to achieve clinical tasks and outcomes, yet adapt and respond to individual patients' needs in a manner that fosters trust and develops the patient-physiotherapist relationship. In this chapter I re-establish how and why my findings were not indicative of patient-centred or biopsychosocial approaches, and describe the implications that this theory-practice gap has for the physiotherapy profession, particularly with respect to practice and education. I provide suggestions for educators teaching interaction, emphasizing the role of reflective practice. The thesis concludes with reflections about the strengths and limitations of the research and suggested directions for future research.

Chapter summary

I have introduced the research in this chapter by explaining my reasons for undertaking this enquiry, and providing broad context, rationale, research objectives, and the argument that shapes the thesis. I concluded this chapter with a thesis outline that illustrated the scope of the thesis. My second chapter is

a critical literature review that synthesizes current knowledge and, in so doing, highlights the gaps in knowledge that this research sought to fill.

Chapter two: A review of the practice and theory of patient-physiotherapist interaction

Introduction

Interaction is an essential component of the dynamics involved in physiotherapy practice. The explicit characteristics, conditions, and methods of interaction, however, require further exploration (Opsommer & Schoeb, 2014; Parry & Brown, 2009; Roberts & Bucksey, 2007). In particular, evidence about physiotherapy-specific communication skills, content, and their effects on physiotherapy practice is required (Parry & Brown, 2009). In this chapter I establish what is empirically known about interaction in physiotherapy and, in so doing, identify some important gaps in the knowledge. The first aim of my research, to explore and describe how patients and physiotherapists interact in private practice, seeks to fill some of these gaps. In addition, this chapter highlights specifics of interaction in physiotherapy and presents theoretical approaches to healthcare interaction that are extensively promoted as appropriate for physiotherapy practice. In detailing the origins and features of these approaches, I question their applicability to physiotherapy practice, thereby justifying my second research aim: to compare my empirical findings with promoted approaches to healthcare interaction.

Hence, this literature review chapter is divided into three main sections: the practice of interaction in physiotherapy, the specifics of interaction in physiotherapy, and interaction theory and physiotherapy. Reflecting the process of my research, to first explore practice and generate empirical knowledge, and then consider theory, I have deliberately structured this chapter with empirical knowledge about interactional practice before discussing theory. I follow this structure throughout the thesis. This chapter begins with a review of the current empirical literature related to interaction in physiotherapy, highlighting significant gaps in knowledge. Emerging from this discussion, I then describe

active patient participation and the use of touch as features of physiotherapy interactions that warrant specific consideration in research and that ought to be present in theories of interaction in physiotherapy. Finally, I outline the theoretical approaches to interaction that are considered potentially relevant to, and representative of, current practices of interaction in physiotherapy. The outline provides reasons why these approaches should be questioned in the physiotherapy setting.

The practice of interaction in physiotherapy

In this section I provide context for my enquiry by reviewing the relevant empirical literature including observational research as well as that reporting patient and physiotherapist perspectives. While much of this research exploring interactions between patients and physiotherapists has been undertaken in hospital and community settings, far less has been conducted in the private practice setting. In addition, considerable research has reported patient and physiotherapist perspectives about interaction. These interview and focus group studies that provide the patient and physiotherapist perspective are useful to inform research, but are inadequate to capture the specifics of interaction in practice. Furthermore, many observational research studies have been undertaken exploring interaction in physiotherapy, but I highlight the disparity in settings, geographical locations, and methods of data collection and analysis that restrict the conclusions that can be drawn. Current knowledge derived from observational research is further fragmented because each study explores different aspects of interaction in different ways. This fragmentation makes it difficult to establish a picture of all features of physiotherapy interactions. To conclude this section, I explain how my research seeks to capture the entirety of the interaction including observational, patient, and physiotherapist perspectives.

Focus on hospital and community settings

Most research that has explored interaction in physiotherapy has been undertaken in hospital and community settings. Parry's (2004a; 2004b; 2005) research exploring goal setting, communication about errors of performance, and interactional management of patients' physical incompetence was set in hospitals in the United Kingdom. A primary care trust (community health centre) was the setting for Roberts and Bucksey's (2007) research, and Thomson (2008) conducted her research about patient-physiotherapist interactions in a chronic pain unit in a United Kingdom hospital. When exploring aspects of interaction in Scandinavia, Oien and colleagues (2011) and Josephson and Bülow (2014) used video-recordings in outpatient clinics and primary care clinics respectively. Video-recordings were used as a method of data collection in many of these studies, and it is possible that this type of observational research was more easily conducted in hospital settings.

In contrast, relatively few research projects exploring interaction in physiotherapy are set in private practice. Thornquist (1990; 1991), Talvitie and Reunanen (2002), Josephson and colleagues (2015), and Schoeb and colleagues (2014) each included some recordings of private practice interactions in their studies that predominantly incorporated hospital or community based interactions. In addition, research has used interviews and focus groups to examine both physiotherapist and patient perspectives of aspects of interaction in private practice (Delany, 2007; Potter, Gordon, & Hamer, 2003a, 2003b, 2003c; Praestegaard & Gard, 2013). Given the prevalence of physiotherapists working in private practice in Australia (Service and Workforce Planning, 2006), and the specifics of this type of practice, such as time pressures and conflicting business drivers (see Chapter one), private practice is a particularly important setting in which to explore patient-physiotherapist interaction.

Perspectives of patient-physiotherapist interactions

Research has explored the physiotherapist or patient perspective about aspects of interaction. This research, generally involving interviews or focus groups, has focussed on what is important to physiotherapists and patients of physiotherapists when they interact with each other. In this section I explore these perspectives, highlighting that both patients and physiotherapists have emphasized the significance of communication, particularly the educative aspects of communication.

Although valuable in imparting patient and physiotherapist perspectives, the results of these studies are limited in that they do not provide knowledge about what actually occurs in interactions between patients and physiotherapists. By highlighting the importance of communication to physiotherapists and patients, these findings do, however, signify the need for more detailed understandings of communication in physiotherapy, particularly with regard to patient participation, non-verbal aspects, and the development of a collaborative, trusting relationship.

The physiotherapist perspective

Physiotherapists have described what they consider constitutes an effective interaction with a patient. Researchers have explored physiotherapists' perspectives about: the entirety of their interactions with patients (Gyllensten, Gard, Salford, & Ekdahl, 1999; Gyllensten, Gard, Hansson, & Ekdahl, 2000); the role of education in interactions (Harman et al., 2011); how they communicate their clinical reasoning (Ajjawi & Higgs, 2012); interacting with difficult patients (Potter et al., 2003a); and expectations of themselves and patients during interactions (Potter et al., 2003b). In addition, physiotherapist perspectives about other aspects related to interactions have been explored, including: ethical issues encountered (Praestegaard & Gard, 2011; Praestegaard & Gard, 2013);

physiotherapists' pain beliefs (Daykin & Richardson, 2004); and physiotherapists' clinical reasoning processes (Josephson et al., 2011). Notably, a number of these studies included physiotherapist participants who practice in the private setting. I go on to explain the facets of interaction that physiotherapists deemed important.

Physiotherapists who were interviewed about important factors for interacting with patients identified both prerequisites related to interaction and specific communicative components of interactions (Gyllensten et al., 1999). They stated that establishing contact, listening, acknowledging facial expressions and body language, and being sensitive were important components of interacting with patients that were framed by a therapeutic process involving patient participation and creating a shared agreement (Gyllensten et al., 1999). Moreover, in the Swedish psychiatric setting, expert physiotherapists highlighted that interaction impacted on patient outcomes and patient awareness of resources (Gyllensten et al., 2000). Building therapeutic relationships by cooperating with patients and use of non-verbal communication were considered particularly important (Gyllensten et al., 2000).

How communication is used to convey clinical reasoning and provide education has been explored from the perspective of physiotherapists (Ajjawi & Higgs, 2012; Harman et al., 2011). An interactional process involving active listening and attending to body-language cues was reported in both studies. In addition, to communicate their clinical reasoning, physiotherapists described a dynamic, largely automatic process that incorporated re-framing the message to match the co-communicator (Ajjawi & Higgs, 2012). When asked about education during consultations with patients, physiotherapists highlighted the significance of communication by expressing their beliefs that education was part of an interactional process (Harman et al., 2011). From these findings, Harman and colleagues (2011) explained that physiotherapists believed education to be

fundamental to building rapport and developing trusting relationships with patients.

In focus group discussions, private practice physiotherapists reported an expectation that patients would respect and trust them, be reliable and compliant, and be actively involved in treatments (Potter et al., 2003b). Equally, physiotherapists explained that they believed that they themselves needed to exhibit caring, empathic behaviours and provide care that is professional and ethical (Potter et al., 2003b). Expressing emotions, particularly the positive emotions of joy and interest, have also been noted by physiotherapists to be important when interacting with patients (Gard, Gyllensten, Salford, & Ekdahl, 2000). Hence, the findings from these studies demonstrate that physiotherapists perceived their use of non-verbal communication as important to engage with patients and to establish some form of collaborative, caring, respectful, trusting relationship.

In addition, physiotherapists in private practice perceived that some patient behaviours preclude effective physiotherapeutic processes and are difficult to manage in physiotherapy interactions (Potter et al., 2003a). These attributes include passive, angry, ill-informed, demanding, non-compliant or dependent patient behaviours. Physiotherapists believed that improvements in their communication skills and an ability to incorporate behaviour modification techniques might assist them to manage these and other challenging patient behaviours in practice (Potter et al., 2003a). These findings again emphasize the value and importance that physiotherapists place on communication skills to engage and manage patients.

Thus, the literature providing the physiotherapist perspective indicates that physiotherapists are cognizant of a need to incorporate specific communicative techniques in their interactions with patients. Findings from this body of research suggest that physiotherapists regard non-verbal communicative

dimensions and establishing an appropriate relationship as important. Moreover, physiotherapists collectively seem to have a perception that patients need to be active participants in interactions with physiotherapists. This suggests that physiotherapists have opinions about the role of patients in their interactions. These findings lead to a plethora of possible research investigations to ascertain whether physiotherapists' opinions correlate with what they are actually doing in interactions with patients.

The patient perspective

Qualitative research has also considered the patient perspective regarding interactions with physiotherapists. Findings about patient priorities and expectations and descriptions of patients' experiences of interacting with physiotherapists have been presented (Ekerholt & Bergland, 2004; Peersman et al., 2013; Peiris, Taylor, & Shields, 2012; Potter et al., 2003c; Rutberg, Kostenius, & Ohrling, 2013). Unanimously, the findings suggest that patients value communication and interactions with their physiotherapist highly. Patients expect physiotherapists to be able to communicate clearly and effectively (Peersman et al., 2013; Potter et al., 2003c); use communication to demonstrate their expertise and professional skills (Ekerholt & Bergland, 2004; Peersman et al., 2013; Rutberg et al., 2013); establish a relationship that is genuine and respectful (Ekerholt & Bergland, 2004; Rutberg et al., 2013); and be empathetic and caring (Peiris et al., 2012). These findings provide fundamental knowledge for physiotherapists about what is important to patients and also informed my research about aspects of communication that are valued by patients. These research findings are limited, however, in that they do not explain how physiotherapists can achieve clear and effective communication that demonstrates their expertise, establishes a relationship, and is empathetic and caring. Developing a detailed explanation for whether and how these facets might occur was an anticipated outcome of this research.

Two qualitative interview studies reflecting patients' perspectives concluded that effective communication, particularly the provision of clear explanations, was the most important dimension of patient-centred physiotherapy (Cooper et al., 2008; Kidd, Bond, & Bell, 2011). From the patient perspective, other important characteristics of patient-centred physiotherapy were therapist confidence, knowledge and professionalism, understanding of individuals, and transparency of progress of treatment (Kidd et al., 2011). Furthermore, patient satisfaction in physiotherapy has been linked with communication and high quality interaction (Beattie, 2002; Hills & Kitchen, 2007). This literature establishes that effective communication is important to patients of physiotherapists. It provides some suggestions about the characteristics of interaction required to achieve patient-centred interactions and improve patient satisfaction, but does not explain how these might be achieved in practice.

Thus, patients place significance on the type and quality of communication received as part of their physiotherapy experiences. For example, provision of clear information as education was highlighted as being particularly important to patients (Beattie, 2002; Cooper et al., 2008; Potter et al., 2003c). By pointing to good communication as a priority and expectation, patients have suggested that physiotherapists need to consider these aspects of practice. These findings demonstrate the importance of, and need for, further research exploring how patient-physiotherapist interactions occur in practice. Detailing the specifics, such as what constitutes good communication and how clear information is provided, through further research will extend physiotherapists' knowledge and ability to improve interactional aspects of their practice.

Research that has explored the patient or physiotherapist perspective from qualitative interviews or focus groups is useful to ascertain aspects of interaction that are important to the participants in patient-physiotherapist interactions and provides suggestions for future exploration. For example, the importance of communication, particularly with regard to providing education, has been

deemed important by both patients and physiotherapists. The limitation of interview and focus group based studies, however, is that they provide perspectives of interaction as opposed to representations of what actually occurs in patient-physiotherapist interactions. Observational research has been described as being an effective means to explore and describe the practice of patient-physiotherapist interactions (Thomson, 2008). I now describe empirical knowledge about interaction in physiotherapy practice derived from observational research. In so doing I explain the applicability of observational research and demonstrate the usefulness of this method.

Knowledge about interaction in physiotherapy derived from observational research

Current knowledge about interaction in physiotherapy derived from empirical observational research exists largely in silos. That is, knowledge about interaction mostly pertains to one aspect of communication, such as decision making or goal setting. Knowledge about discrete aspects of communication is useful as it often allows the derivation of a particularly detailed account. This knowledge can inform practice and education regarding one particular aspect of interaction. However, having silos of knowledge about different aspects of communication makes it difficult to formulate a complete picture of patient-physiotherapist interaction. Furthermore, interactional research in physiotherapy has been conducted in diverse practice settings, different geographical locations, with varying types of data, and via different analysis processes. Consistency and commonality is therefore lacking in observational interaction research, probably because it is such a broad complex topic with many aspects and features that are difficult to measure or outline (Parry, 2005). The major limitation of the current knowledge is that disparate findings are unable to be related to the overall goals of physiotherapy practice to develop a framework or guidelines for the interactional aspects of physiotherapy.

My research endeavoured to explore patient-physiotherapist interaction in its entirety, thus aiming to capture the style and features of interaction as a cohesive whole. This allowed me to develop a framework and explanation that incorporates the different aspects of interaction and communication between patients and physiotherapists. Another significant benefit of observational research exploring the entirety of interaction is that, in contrast to research that seeks to explore one aspect of interactional practice, it allows specific aspects of interaction to be derived directly from the data. Such research potentially provides less intricate detail about specific aspects of communication, but has the considerable benefit of deriving findings that emerge from the data rather than findings being part of preconceived or predesigned categories.

In this section I detail the findings about interactions between patients and physiotherapists derived from observational research. Such findings include styles of interaction, sociological processes, decision making, goal setting, prevalence of communication techniques, non-verbal communication, characteristics of interaction, and incorporation of the patient perspective. Furthering the disparity of findings from observational research in physiotherapy interactions, the analysis techniques that have been applied to observational data include conversation analysis, discourse analysis, thematic analysis, and quantitative analyses. Unifying this knowledge about the practice of interaction derived from empirical observational data provides the reader with background understandings and contexts for my findings presented in Chapters four and five. It also outlines the background knowledge and assumptions about patient-physiotherapist interactions that shaped this research.

Thornquist (1990; 1991; 1994; 1997; 2006) has arguably undertaken the most in-depth explorations of the many facets of patient-physiotherapist interactions. In particular, Thornquist (1997) describes how the practice of physiotherapy is embedded in social processes of interaction and proposes that interaction and diagnostics or clinical aspects of practice are integrated as a 'mutually

constitutive process' (p.324). Analyzing two patient-physiotherapist interactions in detail, Thornquist (1994) concluded that physiotherapists used a biomedical, dualistic frame of reference for clinical tasks of assessment and treatment, but added a human factor relating to patients as a whole through their general communicative actions. That is, physiotherapists separated their knowledge, using specific professional knowledge and a clinical approach to the body, and also contextualized knowledge for the everyday relational aspects of their interactions with patients (Thornquist, 1994). These findings suggest that interaction in physiotherapy functions to achieve clinical tasks as well as to develop human relations with patients. Later, Thornquist (2006) provided further insights into how physiotherapists view and approach 'the body' in interactions with patients, reporting that physiotherapists practice and reason in a variety of ways, some being guided by assumptions from a biomedical paradigm, and some interpreting the body as an embodied part of a broader whole. These insights suggest that physiotherapists do not necessarily have a common, unified approach to interacting with patients.

A few studies have explored interaction in its entirety, resulting in nuanced accounts of the processes and characteristics of interactions between patients and physiotherapists in physiotherapy. Two such studies exploring physiotherapeutic interactions with patients experiencing chronic pain both suggested that a process of negotiation and seeking common ground produced an optimal pattern of interaction (Oien et al., 2011; Thomson, 2008). Thomson (2008) described positive outcomes resulting from interactions where patients actively sought to improve and change their lives by including assertive conversations, negotiations with physiotherapists, and an element of critical reflection that had the ability to be transformative. In descriptions of seeking common ground, Oien and colleagues (2011) explained how both patients and physiotherapists contributed and negotiated in a gradual and tentative manner. Their descriptions suggested that much of the negotiation occurring within

interactions was implicitly understood through non-verbal processes (Oien et al., 2011).

These optimal patterns of interaction, characterized by a process of negotiation to seek common ground, were contrasted with interactional patterns that were challenged in some way. Thomson (2008) presented two other groups of interactions. One group involved patients who did not align themselves with, or were resistant to, the focus of the pain management programme. The other group was characterized by interactions that appeared to be collaborative but were driven by the physiotherapist and incorporated a patient who had filled the role of a good patient without being personally motivated (Thomson, 2008). These accounts attribute the success or failure of interactions in the pain management programme to the characteristics or attitudes of the patient. In contrast, Oien and colleagues (2011) attributed challenges to the negotiating pattern of interaction to both physiotherapists and patients. Two patterns of challenges to interaction were identified: ambivalence and uncertainty, and impatience and disagreement (Oien, 2011). These findings suggest that both physiotherapists and patients need to be motivated to work together in a critically reflective and sensitive manner to successfully negotiate and find common ground in their interactions. Both of these studies have contributed rich details about the specific sociological processes of interactions and characterized components of these interactions, and have furthered understanding about the process of interaction in physiotherapy.

Aspects of the patient-physiotherapist interaction have been researched and provide insight into the components or stages involved. Setting and achieving goals, emphasizing motor activity, optimizing training strategies, facilitating patients to be actively involved, and using environmental factors were identified as characteristics of physiotherapy interactions with stroke patients in rehabilitation units (Wohlin Wottrich, Stenström, Engardt, Tham, & Von Koch, 2004). This research included observations and interviews with patients and

physiotherapists, and found that patients and physiotherapists had some different perceptions. Patients trusted in physiotherapists' competence with regard to optimizing training strategies, but physiotherapists perceived that their own knowledge was lacking. Also, with respect to facilitating active patient involvement, physiotherapists believed that they were incorporating the individual patient's characteristics, but patients considered that their personal knowledge and circumstances were not accounted for (Wohlin Wottrich et al., 2004). These differences demonstrate the value of incorporating both observation and interview data to capture the different perspectives regarding aspects of interaction.

In her dissertation, Delany (2005) also characterized patient-physiotherapist interactions by outlining an inherent structure incorporating assessment, diagnosis, and treatment. In these structured interactions, physiotherapists were reported to 'build clinical fences' by leading the interaction and limiting patient contributions and input (Delany, 2005, p. 168). Physiotherapists leading aspects of the interaction may limit both patients' involvement and physiotherapists' opportunity to incorporate patient perspectives and understandings. Limited patient involvement and contributions are also characteristics of interactions apparent in other research findings (Josephson & Bülow, 2014; Opsommer & Schoeb, 2014).

Josephson and Bülow (2014) specifically considered the utilization of patient 'resources' by physiotherapists when interacting with patients with low back pain in Sweden. The authors clarify that patient resources include their personal characteristics, social conditions, physical objects, and abilities to acquire resources. Integrating these resources by including patients' views and preferences into patient management are considered essential to physiotherapy practice (Josephson & Bülow, 2014). Their findings demonstrated that physiotherapists were utilizing only some patient resources, particularly those relating to activities happening during the interaction. Underutilized resources

often related to the life-world perspective of each patient, including their personal characteristics and motivators (Josephson & Bülow, 2014). In addition, communication strategies, such as the use of closed-ended questions and asking questions in the format of documentation, were observed during initial interactions between physiotherapists and patients with low back pain (Opsommer & Schoeb, 2014). The authors concluded that the focus on investigating and objectifying pain restricted elicitation of the patient perspective (Opsommer & Schoeb, 2014). These findings are similar to those described by Wohlin Wottrich and colleagues (2004), where patient contributions were not optimized.

As a characteristic of interactions in physiotherapy, decision making has received research attention with findings suggesting that, in the main, physiotherapists make decisions for their patients (Dierckx, Deveugele, Roosen, & Devisch, 2013; Jones et al., 2014). Incorporating 210 and 80 consultations between physiotherapists and patients in Belgium and the United Kingdom respectively, evaluation using a quantitative assessment tool provided findings in two studies that revealed shared decision making to be underdeveloped or not applied in patient-physiotherapist interactions (Dierckx et al., 2013; Jones et al., 2014). Patient views or expectations were not often sought, and patients' preferences for involvement in decision making and receiving information were not usually considered (Jones et al., 2014). These findings contrast with the shared decision making approach that is unanimously promoted throughout the physiotherapy literature (Dierckx et al., 2013; Smith, Ajjawi, & Jones, 2009). Patients, however, preferred to provide their opinion about treatment and to be involved in decision making (Dierckx et al., 2013). Similar evidence exists for the process of goal setting in patient-physiotherapist interactions.

Collaborative goal setting is promoted in physiotherapy (Schoeb, 2009). Practice guidelines implore physiotherapists to include patients in goal setting (Australian Physiotherapy Association, 2011). However, studies in the United

Kingdom and Switzerland reported that many patient-physiotherapist consultations did not contain explicit goal setting processes (Parry, 2004a; Schoeb, Staffoni, Parry, & Pilnick, 2014). Episodes of goal setting that did occur in physiotherapy interactions often had possible goals or features of goals 'supplied' by physiotherapists; patients' contributions were limited to brief answers in agreement with physiotherapists' proposals (Parry, 2004a). Another study reported that interactional difficulties arose during goal setting processes because the physiotherapist asked questions that implied that patients understood what would constitute a physiotherapy-specific goal, and already had a goal in mind (Schoeb et al., 2014). Patients had difficulties providing a goal, and their delayed responses were indicative of problems with communication (Schoeb et al., 2014). Thus, goal setting in physiotherapy is complex, and current research suggests that physiotherapists and patients have difficulties implementing the guidelines of collaborative goal setting.

Aside from studies investigating decision making, there has been minimal quantification of aspects of communication in the patient-physiotherapist interaction. This contrasts to the extensive research quantifying aspects of communication and interaction in medicine. A number of different quantification systems, such as the Roter Interaction Analysis System (RIAS) (Roter & Larson, 2002), are frequently used in wider healthcare communication research.

As an exception, Roberts and colleagues (2007; 2013) implemented the Medical Communications Behaviour System to quantitatively analyze and record frequency of different types of verbal and non-verbal communication in interactions between patients with lower back pain and their physiotherapists. Their findings indicated that physiotherapists talk almost twice as much as patients (Roberts & Bucksey, 2007; Roberts et al., 2013). Talking concurrently and interrupting patients was also relatively prevalent, particularly in interactions involving experienced physiotherapists; moreover, discussion about emotions was limited (Roberts et al., 2013). In addition, of five non-verbal

behaviours quantified, physiotherapists' use of touch (54%) and eye gaze (32%) were the most prevalent; patients predominantly used eye gaze (84%) (Roberts & Bucksey, 2007). Affirmative head nodding, forward leaning, and smiling were less apparent among physiotherapists and patients (Roberts & Bucksey, 2007). Therefore the indications are that physiotherapists dominate the conversation and that eye gaze and touch are important parts of non-verbal communication in physiotherapy interactions. This type of research provides a clear picture of the frequency of different types of communication occurring in practice, but the findings are limited to pre-determined categories of communication, and lack rich descriptions of the dynamic processes involved in interactions in practice.

In addition to Roberts and Bucksey's (2007) research, a small number of other studies have explored non-verbal communication in physiotherapy. Perry (1975) observed patient-physiotherapist interactions in a hospital setting and recorded eye contact, nodding, and touch as frequent non-verbal communications initiated by the physiotherapist. Perry's (1975) research also indicated that nodding and following instructions were frequent non-verbal responses used by patients. To further these findings, Thornquist (1990; 1991) recorded insights about the implicit role of communication in three different physiotherapy settings, and detailed aspects of bodily communication, commonly termed non-verbal communication, such as eye gaze and touch, that convey care and attentiveness toward the patient.

Other observational research has since highlighted the prevalence and significance of touch throughout interactions with patients (Bjorbaekmo & Mengshoel, 2016; Roger et al., 2002). In the inpatient setting, touch was used to perceive information, assist and facilitate movement, prepare the patient, provide information, provide therapeutic intervention, build rapport and extend care to the patient (Roger et al., 2002). Touch in physiotherapy is therefore prevalent, functional as part of assessment and treatment, sensitive and responsive to patients' needs, individualized, and conveys care for the patient

(Bjorbaekmo & Mengshoel, 2016; Roberts & Bucksey, 2007; Roger et al., 2002). In correlation with perspectives from patients and physiotherapists provided in interview and focus group research, these findings signify that non-verbal communication, particularly touch, has special significance in the physiotherapy context. Further exploration of patient-physiotherapist interactions is required to understand the role and functions of non-verbal communication. As noted above, observational methods are the most appropriate means of ascertaining this information.

This section has outlined the various areas or 'silos' of knowledge that have been derived from observational data including decision making, goal setting and use of patient 'resources'. It has also included descriptions of the few studies that have explored the entirety of patient-physiotherapist interactions using ethnographic methodologies, and has demonstrated the value of these methods in generating rich, nuanced and detailed accounts of the processes involved in the practice of interaction in physiotherapy. To contribute to this field, my research also seeks to explore the entirety of patient-physiotherapist interactions, but will focus on the private practice setting that, until now, has received minimal attention.

To further my development of the context of this research, the next section details the specifics of interaction in physiotherapy. These specifics were ubiquitous in the first section of this chapter as significant facets of interaction and are also a feature of the normative literature. It is important to determine them because they are potential identifiers of the essence of the practice of physiotherapy as a healthcare profession.

Specifics of interaction in physiotherapy

The literature alludes to two specific features of patient-physiotherapist interaction. First, the focus on movement and the active nature of physiotherapy

treatment constitutes a need for active patient participation. Second, the extensive use of touch and subsequent close physical relationship between patient and physiotherapist is a defining feature of patient-physiotherapist interactions. These characteristics are substantiated in both the normative and research literature. In this section I detail current knowledge about these particulars, and justify why interactions with patients in physiotherapy ought to be examined independently of patient-practitioner interactions in other healthcare settings.

Patient participation

Patient participation is an essential component of successful physiotherapy treatment (Barron, Moffett, & Potter, 2007). The aim of physiotherapy is to optimize patient movement and function (WCPT, 2011). Hence active therapy, exercises, and self-management strategies for patients to implement into their daily activities are considered central to physiotherapy treatment (Higgs et al., 2001). These interventions require patients to participate and to take some responsibility for their rehabilitation. Many treatments that physiotherapists use cannot be successful without input and motivation from the patient to cooperate and collaborate both during and beyond the interaction itself (Parry, 2009). As research participants, physiotherapists themselves have recognized that patient participation is important in their interactions (Gyllensten et al., 1999).

One of the drivers of physiotherapy practice is that the physiotherapist is guiding the patient to achieve self-management (Main & George, 2011). The individual patient must therefore be engaged and actively involved in each stage of the treatment. The patient cannot be a passive recipient but needs to demonstrate commitment and involvement in the process of rehabilitation (Poulis, 2007b). Physiotherapists also have a considerable role in providing advice and education

and in supporting patients to learn the appropriate activities (Harman et al., 2011; Parry, 2009).

The requirement for self-efficacy could be considered a physiotherapist-imposed goal that aligns with the concept of adherence. In the physiotherapy context, adherence refers to a patient's capacity to co-operate with and continually utilize exercises and other prescribed regimens designed to optimize physical functioning (O'Carroll & Hendriks, 1989; Redmond & Parrish, 2008). The efficacy of many aspects of physiotherapy relies on this type of adherence and engagement from patients, as part of a reciprocal arrangement with the physiotherapist (Redmond & Parrish, 2008). For this reason, the concept of adherence is frequently assessed in research (Lonsdale et al., 2012; Tijou, Yardley, Sedikides, & Bizo, 2010). Moreover, there is some evidence that patient adherence is influenced by the quality of the patient-practitioner relationship and communication (Klaber Moffett & Richardson, 1997; Wright, Galtieri, & Fell, 2014; Zolnieriek & DiMatteo, 2009). Given that the need for active patient participation and adherence to treatment plans is a defining feature of patient-physiotherapist interactions, the role and potential of communication to appropriately assist patient participation and adherence is an area that requires more directed and empirical research.

Significance of touch

Touch has been identified as a defining feature of the professional identity of physiotherapy: it is ever present, aligns with the physical body, and is central to the focus of physiotherapy treatments (Helm, Kinfu, Kline, & Zappile, 1997; Nicholls & Gibson, 2010; Nicholls & Holmes, 2012). Manual and touching therapies have long been at the centre of physiotherapy practice (McMeeken, 2014). The frequency and significance of touch has been substantiated both qualitatively (Bjorbaekmo & Mengshoel, 2016; Roger et al., 2002), and quantitatively (Roberts & Bucksey, 2007). As a result of the high frequency of

touch, the close physical relationship between patient and physiotherapist heightens communicative and ethical considerations for physiotherapists (Poulis, 2007a).

Perry (1975) wrote about the potency of communication through touch in physiotherapy. Surprisingly, relatively few authors have since considered touch as a communicative medium in physiotherapy. Roger and colleagues (2002) categorized types of touch used by physiotherapists in an inpatient setting. This touch was assistive, preparative, educational, caring, interventional, and perceptive. Their findings implied that physiotherapists use touch to convey and perceive information as a subtle and often implicit communicative tool. BJORBAEKMO and MENGSHOEL (2016) furthered the discussion with their descriptions of touch as a 'silent, touching, moving dance' (p. 16): a bodily conversation that was sensitive, responsive, and expressive. It seems that significant parts of interaction occur through touch in physiotherapy interactions. Future research considering what and how meanings are conveyed through touch in physiotherapy interactions will contribute to knowledge about this important aspect of physiotherapy practice.

Research about touch in physiotherapy mostly pertains to its physiological impacts on the patient via manual therapy. For example, manual therapy techniques have been demonstrated to reduce pain and improve flexibility in those with neck pain (Fernández-de-las-Peñas, Palomeque-del-Cerro, Rodríguez-Blanco, Gómez-Conesa, & Miangolarra-Page, 2007; Leaver et al., 2010; Sterling, Jull, & Wright, 2001), and manual or touching treatment techniques have been compared with a mechanical device to perform a treatment (Waddington, Lau, & Adams, 2007). Perhaps because of the ethical challenges, there is comparatively more literature discussing the use of touch in psychotherapy than in physiotherapy (for example, Durana, 1998; Horton, Clance, Sterk-Elifson, & Emshoff, 1995; Smith, Clance, & Imes, 1998; Stenzel & Rupert, 2004). Given the significance of touch in physiotherapy, the lack of discussion and specific

exploration of touch in patient-physiotherapist interactions is notable and warrants further exploration.

Thus, current literature suggests that interactions between patients and physiotherapists have some defining features that differentiate interactions in physiotherapy from those of other health professions. Further exploration of how interaction occurs in physiotherapy practice, particularly with regard to the nature of patient participation and the use of touch, would assist physiotherapists to understand and improve these aspects of their practice. In addition, these features of interaction specific to physiotherapy justify the need to question and develop theory of interaction between patient and physiotherapist, rather than defaulting to a process of extrapolating from theories of patient-practitioner interactions from other professions.

Interaction theory and physiotherapy

In 1952, Lewin and Cartwright wrote: 'there's nothing more practical than a good theory' (p. 169). In healthcare professional practice, theory is considered to be supportive of practice by providing conceptual explanations that capture and frame the specifics of an aspect of practice. Good theories need to be practically applicable, present detailed facts about phenomena in a coherent manner, and provide concepts to assist conceptualization of ideas or conditions (Vansteenkiste & Sheldon, 2006). The benefits of theory to a profession such as physiotherapy are that it supports the advancement of knowledge, guides further research, and enlightens educational and other management aspects of the profession (Van de Ven, 1989). Theory about interaction in physiotherapy is therefore vital to support education, further research, and most importantly, provide a framework for the practice of interaction in physiotherapy.

To be considered credible and evidence-based, the practice of interaction in physiotherapy should be purposefully based upon and align with theoretical

frameworks and evidence from empirical research (Chan & Clough, 2010). The 'theory-practice gap' is the term used in healthcare when theory is distanced from practice (Scully, 2011). A theory-practice gap is probable in the context of interaction in physiotherapy for two reasons. First, theories such as patient-centred care that are espoused for physiotherapy have been derived from medical theories and therefore may not be relevant and applicable for the specifics of physiotherapy interactions. Second, a small body of literature questions whether endorsed theoretical explanations for physiotherapy interaction align with evidence representing the practice of interaction in physiotherapy (Cruz et al., 2012; Opsommer & Schoeb, 2014). For these reasons a misalignment between theory and practice of interaction in physiotherapy is probable, and research into the connection between theory and practice is required.

Another question about current theoretical explanations for healthcare interactions is whether they provide sufficient conceptualization to actually be termed theories. In the literature, descriptions for interactions are referred to as 'models', 'approaches', 'paradigms', 'frameworks', or 'theories'. These words are often used interchangeably and are rarely defined. To reduce this ambiguity and provide consistency and clarity I outline the definitions I am using for these terms throughout the thesis. I use Vansteenkiste and Sheldon's (2006) definition of theory as a practically applicable tool that provides detailed facts and concepts coherently, with the aim to allow conceptualization of an idea or condition. I also consider that a theory needs to be verified by empirical research (Epstein & Borrell-Carrio, 2005). In this thesis I deem a paradigm to be a broader, accepted set of ideals, and refer to a paradigm as a 'world view underlying the theories and methodology of a particular scientific subject' (Oxford Dictionaries, 2016). For example, I portray biomedical ideals as a paradigm as it is a widely accepted and evidenced way to perceive healthcare practice.

In addition, other terms such as approach, framework, and model are frequently used in the healthcare communication literature. An approach is 'a way of dealing with a situation' (Oxford Dictionaries, 2016), and in this thesis I consider an approach to be a less robust or less evidenced description of a situation or phenomena. Likewise, I deem a framework, or 'basic structure underlying a concept' (Oxford Dictionaries, 2016), to be slightly more developed than an approach without providing enough detailed explanation to be termed a theory. I have avoided using the word 'model' in relation to interactional approaches because the use of the word 'model' has been criticized in relation to the biopsychosocial approach and is difficult to clearly define (McLaren 1998, 2006). Thus, I use the terms 'paradigm' and 'theory' as overarching terms that have established evidential support for their explanations, and 'framework' or 'approach' as less robust descriptions that could be elevated to theories through provision of practically applicable conceptualizations and appropriate evidential support.

Inconsistencies in nomenclature are one of many challenges surrounding approaches to healthcare interaction. These approaches, such as patient-centred care, are labelled and described differently by different authors and are, in general, not based on empirical research findings. Moreover, these approaches are often described as paradigms or philosophies for the entirety of healthcare practice, and at the same time are also referred to as 'frameworks' for interactional or communicative aspects of practice (Epstein & Borrell-Carrio, 2005). This lack of clarity potentially limits their application in practice. Furthermore, when applying these approaches to practice it becomes evident that there is considerable overlap. That is, different approaches are not mutually exclusive. Any given interaction is unlikely to be entirely directed by or indicative of one or other approach.

With these challenges in mind, in this section I provide detail about the origins and commonly described features of the two main approaches to healthcare

interaction: practitioner-centred and patient-centred. In so doing, I highlight the need to question their applicability to interactions in physiotherapy.

Approaches to healthcare interaction

In broad terms, there are two promoted approaches relevant to and potentially representative of healthcare interactions: the practitioner-centred approach and the patient-centred approach (Byrne & Long, 1976; Mead & Bower, 2000).

Descriptions of these approaches incorporate the focus of the interaction, and contain elements of communication including structure, questioning style, and type of content (Roter, 2000). Other aspects of these interactional approaches are less visible and include assumptions about roles and responsibilities of the patient and practitioner, aspects of power and authority, and the type of relationship between patient and practitioner that is valued and encouraged through interaction (Kaba & Sooriakumaran, 2007; Trede & Higgs, 2009). I next outline these two broad approaches as they appear in the literature and critique their value in the physiotherapy setting.

The practitioner-centred approach

Until relatively recently, the physician-, disease-, doctor-, or practitioner-centred approach has been the traditional approach to interacting with patients in healthcare (Byrne & Long, 1976; Levenstein, McCracken, McWhinney, Stewart, & Brown, 1986; Smith & Hoppe, 1991). Biomedical ideals also align with this approach, and the terms 'biomedical' and 'practitioner-centred' or 'paternalistic' are often used interchangeably when referring to interactions or communication in healthcare.

Using a biomedical approach means that the practitioner focuses on biological causes and explanations for the patient's presenting condition (McCollum & Pincus, 2009). A scientific and clinical basis underpins the biomedical approach

directing the practitioner to identify, diagnose, and then cure the problem identified by the practitioner (McCollum & Pincus, 2009; Wade & Halligan, 2004). A focus on biological dimensions with a high percentage of biomedical information discussed by both patients and practitioners is therefore central to a biomedical or practitioner-centred approach (Roter et al., 1997; Smith, Fortin, Dwamena, & Frankel, 2013). Equally, a relatively small percentage of conversation about psychosocial topics is reported as being a feature of biomedical, practitioner-centred interactions (Roter et al., 1997).

In addition, interactional features of a practitioner-centred approach include a high percentage of practitioner-initiated questions that are closed-ended, specific, and direct (Roter et al., 1997). Authors also suggest that when a practitioner-centred approach is implemented, the relationship between patient and practitioner is overtly controlled and directed by the practitioner's discipline-specific biomedical agenda (McCollum & Pincus, 2009; Roter et al., 1997). Although the biomedical and practitioner-centred approaches have been deemed highly successful approaches to treat disease, they have been heavily criticized in healthcare literature for dichotomizing body and mind, and neglecting the psychosocial and human dimensions of patients and their presentations (Borrell-Carrio, Suchman, & Epstein, 2004; Engel, 1977). In healthcare, including physiotherapy, this style of interaction is no longer regarded as optimal.

The patient-centred approach

A patient-centred approach, often termed 'patient-centred care', involves practitioners gathering information and tailoring treatment according to the needs and perspectives of the individual patient (Bensing, 2000). A patient-centred approach aligns closely with a biopsychosocial approach, and the terms 'biopsychosocial' and 'patient-centred care' are used interchangeably by some authors (Smith et al., 2013). Potential points of difference are that

biopsychosocial approaches reflect the topics or content covered, and patient-centred interaction or communication is the process used to achieve a patient-centred or biopsychosocial approach.

The biopsychosocial approach was described by a psychiatrist, Engel (1977; 1978), who proposed that psychological and social aspects of each patient required consideration in medical practice. He based his descriptions on general systems theory explaining how all aspects of a person from atoms and molecules, to organs and systems, through to the society and culture in which he or she associates, are inter-related (Engel, 1978). These early descriptions of a biopsychosocial approach were not derived from research evidence but, rather, were philosophical suggestions about an ideal way to practise medicine: incorporating biological, psychological, and social components. The biopsychosocial approach has since become a revolution in healthcare as a highly valued and important framework for practice (Smith, 2002).

With regard to interacting with patients, the biopsychosocial approach suggests that biological, psychological, and social aspects of the patient's presentation all need to be considered and integrated within interactions in a way that incorporates the patient's narrative and experiences (Engel, 1978; Epstein et al., 2003). Research has reported that a biopsychosocial interaction therefore includes a relative balance between biomedical and psychosocial content (Roter et al., 1997). In addition, a biopsychosocial pattern of interaction involves relatively fewer questions asked by physicians, compared with a biomedical approach, and involves more social talk in the conversation (Roter et al., 1997). Hence, beyond the incorporation of the three central characteristics of the patient, biological, social, and psychological, descriptions about how the biopsychosocial approach is implemented in healthcare practice remain limited. Furthermore, features that are stated to be indicative of biopsychosocial communication lack support from empirical evidence; this is verified by the fact

that Smith and colleagues (2013) have been retrospectively undertaking research to provide evidential support for the biopsychosocial approach.

A patient-centred approach has also been developed as part of a shift away from the medicalization that occurred in the nineteenth and early twentieth centuries (May & Mead, 1999). A patient-centred approach represents a moral adjustment in healthcare practice seeking to increase care for each person as an individual (May & Mead, 1999). As Epstein (2011) explained, 'philosophically, patient-centred care is an approach to care and perceived as the right thing to do' (Epstein & Street, 2011, p. 101). To implement a patient-centred approach, the practitioner uses cues about what is important to patients themselves and incorporates the patient's narrative and experiences (Bensing, 2000). The patient-centred practitioner respects and is guided by individual patient knowledge and experience (Byrne & Long, 1976). Moreover, some consider that to be patient-centred the practitioner needs to understand the patient's experience from the patient's perspective (Stewart, 1995).

In a seminal review of patient-centredness, Mead and Bower (2000) described five core characteristics: incorporating a biopsychosocial perspective; considering and respecting the patient as an individual; sharing decision making, information, power, and responsibility; viewing the relationship between patient and practitioner as a therapeutic alliance; and self-awareness on the part of the practitioner. Patient-centred care therefore centres on helping patients be more active in interactions and achieving a collaborative relationship (Epstein & Street, 2011).

Specific communicative aspects of a patient-centred interaction are the use of an open-ended and non-directive questioning style, avoiding interrupting patients, and responding empathically to emotion (Smith et al., 2013). The patient-centred interaction incorporates a biopsychosocial perspective whereby the practitioner follows the patient's lead to identify relevant social and psychological

components (Mead & Bower, 2000). In addition, a patient-centred approach is described to be collaborative with patients involved in decision making and sharing of information (Grol, de Maeseneer, Whitfield, & Mokkink, 1990; Winefield, Murrell, Clifford, & Farmer, 1996). Although some communicative features of a patient-centred approach have been outlined, exactly whether and how these are implemented in communicative practice remains difficult for practitioners to interpret.

The patient-centred and biopsychosocial approaches are advocated as particular styles of interacting with patients. While they are based on moral values, descriptions and examples of specific communicative components that constitute the implementation of these approaches in practice are lacking. Furthermore, without empirical evidential support, it is not known whether and how they are connected to the reality of clinical practice. Roter's (1997) research is one of the few examples that has attempted to delineate specific communicative components of each approach to assist practitioners to understand how to be 'patient-centred' or 'biopsychosocial' during interactions with patients. My research, in the physiotherapy setting, aims to provide detailed descriptions of the practice of interacting and then to consider how these findings relate to approaches to healthcare interaction. It is anticipated that these findings will offer empirically derived theoretical explanations about how interaction occurs in practice, and will, in turn, extend views of current approaches or be a foundation for new avenues of interaction theory for physiotherapy.

Application of healthcare interaction approaches to physiotherapy practice

Although the patient-centred and biopsychosocial approaches were both developed for the medical profession, the physiotherapy profession heavily promotes both of these approaches. Patient-centred and biopsychosocial approaches are strongly endorsed in codes of conduct (Physiotherapy Board of

Australia, 2014; National Physiotherapy Advisory Group, 2009), position statements (Australian Physiotherapy Association, 2012), and physiotherapy literature (for example, Hunt, Birmingham, Skarakis-Doyle, & Vandervoort, 2008; Jones et al., 2002; Overmeer, Boersma, Main, & Linton, 2009; Pinto et al., 2012; Sanders et al., 2013). Guidelines and research discussions almost unanimously encourage physiotherapists to practise and interact with patients in accordance with these frameworks.

Several important questions, however, need to be asked about the applicability of biopsychosocial and patient-centred approaches to physiotherapy interactions. First, because they were developed for the medical profession and are not derived from empirical research, it is necessary to question whether they are actually relevant and applicable to the practice of physiotherapy. Interactions between patients and physiotherapists differ from those in the medical scenario in that they involve active patient participation and considerable use of touch.

Moreover, some empirical research findings suggest that physiotherapists are not currently practising in either a patient-centred or biopsychosocial manner (Cruz et al., 2012; Opsommer & Schoeb, 2014). In the literature reporting observational research about aspects of interaction in physiotherapy, some authors have discussed how their findings relate to paradigms, theories, or approaches to interaction. For example, Cruz and colleagues (2012) describe a pattern of interaction that incorporates closed questions, avoids patient perspectives about their specific problems, focuses on understanding the clinical condition, and is controlled by the physiotherapist. This pattern is characteristic of a biomedical, practitioner-centred approach to interaction, and the authors explain how this contrasts to the promoted patient-centred approach (Cruz et al., 2012). Other authors who have undertaken observational research in physiotherapy have also discussed how their findings were more representative

of a biomedical than a patient-centred approach (Josephson et al., 2015; Opsommer & Schoeb, 2014).

Further patterns of interaction derived from observational research that I outlined in the first section are also indicative of a biomedical or practitioner-centred approach. Examples of practitioner-centred features are physiotherapists undertaking decision making (Dierckx et al., 2013; Jones et al., 2014), the predominance of physiotherapist talk (Roberts & Bucksey, 2007), and limited incorporation of the patient's perspective (Josephson & Bülow, 2014; Opsommer & Schoeb, 2014). These findings suggest that there may be a gap between the practice of interaction represented in empirical research findings and the theoretical approaches purported to be occurring in practice. The possible existence of a theory-practice gap has implications for education and practice within the profession of physiotherapy. My research seeks to derive knowledge about the practice of interactions in physiotherapy and to compare with theoretical approaches, thereby directly addressing the concern regarding a theory-practice gap.

A second question involves the uncertainty regarding how the biopsychosocial and patient-centred approaches are implemented in physiotherapy interactions. Clear descriptions are lacking. Jones and colleagues (2002) highlighted the challenges associated with integrating new approaches into practice. To assist, they developed what they termed 'conceptual models' of the biopsychosocial approach and gave examples of how these might be implemented in clinical practice (Jones et al., 2002). However, there remains very little specific information regarding the types and styles of communication physiotherapists should use to interact in a patient-centred or biopsychosocial manner.

Alternative means of interacting with patients have been suggested. These include an emancipatory approach (Trede, 2012; Trede et al., 2003), a social humanistic approach (Lundstrom, 2008), and a psychotherapy approach

(Szybek, Gard, & Lindén, 2000). In addition, physiotherapists are beginning to consider other approaches derived from psychology, such as cognitive behavioural therapy and motivational interviewing, to achieve behavioural change (Harman, MacRae, Vallis, & Bassett, 2014; Holden, Davidson, & O'Halloran, 2015; O'Sullivan, 2012). Although these approaches all have theoretical and social merit, their practical application in physiotherapy is largely unexplored. Whether any of these approaches form adequate theoretical representations of interactions in practice is unknown. The very fact that alternative approaches are being suggested implies that patient-centred and biopsychosocial approaches may not be applicable to physiotherapy practice in their current forms.

Chapter summary

I began this chapter by reviewing the literature reporting empirical research that investigated aspects of how interaction is practised in physiotherapy and identifying key areas that require further investigation. In the process I have established that observational methods are the appropriate method to inductively explore patient-physiotherapist interactions as they best capture the essence and specifics of how interactions occur in practice. I have also shown that current observational literature in physiotherapy exists in silos, mostly related to just one aspect of interaction, thereby justifying my research exploring the entirety of interactions between patients and physiotherapists. Finally, the relative paucity of research in the private practice setting provides a further rationale to use private practice as the setting for this research.

The second section of this chapter highlighted specific features of interactions in physiotherapy, explaining that active patient involvement and frequent use of touch occur because the physiotherapy profession seeks to improve movement. These specifics justify the need to examine interactions in physiotherapy as distinct from interactions in other healthcare professions. The chapter concluded

with descriptions of theoretical approaches to interaction in healthcare that are recommended for physiotherapy practice. Questions about whether and how promoted approaches are actually implemented in physiotherapy practice were raised. These questions validate the second aim of this research: to consider the relevance of established approaches to healthcare interaction in physiotherapy.

The aims for this research were first, to describe patient-physiotherapist interactions in the private practice setting using inductive observational methods; second, to compare the empirically derived findings with currently promoted approaches to healthcare interaction. In undertaking this comparison, I seek to consider whether biopsychosocial and patient-centred approaches are representative of interactions in the physiotherapy private practice setting.

Having provided rationales for the research aims and justified the choice of methods, in Chapter three I explain the methods in detail. The chapter provides descriptions of the conceptual and methodological frameworks that directed this enquiry. It also outlines the processes used in this research to generate findings. Throughout the methods chapter I make my role as the researcher visible, explaining how I incorporated reflexive practices to assist to increase the rigour of the research.

Chapter three: Methods

Introduction

Research begins with questions (Shepard et al., 1993). Aiming to explore and understand the patient-physiotherapist interaction, the question for this research was: 'how do patients and physiotherapists interact with each other in the private practice setting?' For an open research question beginning with 'how', an inductive, qualitative research approach was appropriate to provide the required data (Creswell, 1998). I chose the interpretive paradigm as the conceptual framework, and used aspects of ethnography and grounded theory as methodological frameworks. In this chapter I justify these choices as the means to obtain data and derive findings that would best answer the research question. Although not rigidly situated within one tradition, these conceptual frameworks and methodologies complement each other. I aimed for coherence between research question, research paradigm, and supporting theoretical frameworks. This structure allowed me to situate myself within the research as the researcher and to develop an acute awareness of my role in the planning, data collection, analysis, results, and dissemination of the research.

This chapter outlines the conceptual frameworks that informed the research, and demonstrates how my methods of recruitment, data collection and analysis aligned with these. I detail the methods used including: recruitment and sampling, the participants and settings, observations and interviews as fieldwork, transcription, coding, memo-writing, concept mapping, and finally, comparisons between findings and established approaches to healthcare interaction. Although I have written these methods as a chronological representation of the research processes, in reality there was considerable overlap and cycling back and forth between stages of data collection and analysis. I conclude the chapter with a discussion about my role as the researcher, ethical considerations, and the use of reflexivity.

Conceptual framework

Conceptual frameworks provide a basis and referential point from which to view research and to address the research question. In keeping with a qualitative research project, I situated this study within the interpretive paradigm (Byrne-Armstrong, Higgs, & Horsfall, 2001; Petty, Thomson, & Stew, 2012a). In this section I detail the interpretive paradigm and describe why and how it was relevant to my research context.

Interpretivism

The interpretive paradigm encompasses research approaches that seek to interpret and understand the social world (Higgs, 2001; Holloway & Wheeler, 2010). Knowledge generated within the interpretive paradigm is the result of a search for meaning constructed from the minds and bodies of conscious, knowing beings (Higgs, 2001). Aligning with the goals of the interpretive paradigm, the present goals were to understand, describe, and interpret the naturally occurring social phenomena of patients and physiotherapists interacting with each other using an inductive approach (Higgs, 2001; Townsend, Cox, & Li, 2010). In addition to interpreting and describing what occurred in the interaction, I sought to understand the perspectives of the people involved in the interaction and to derive meanings from these perspectives. My ontological perspective during the planning and implementation of this research was interpretivist as I viewed subjectivities as being integral to practice and I incorporated a number of perspectives in recognition that there are multiple realities (Petty et al., 2012a).

The theoretical paradigm of interpretivism permeated all aspects of my research from the philosophical perspective to research purpose, design and methods, as well as dissemination of research results (Shepard et al., 1993). In particular, the aim of the research to understand 'how patients and physiotherapists interact' is

interpretivist because there was no prediction about what the data would demonstrate. Also in alignment with the interpretive paradigm, I used multiple methods of data collection and inductive analysis to generate understandings of the social interaction between patients and physiotherapists (Higgs & McAllister, 2001).

Within the interpretive paradigm I sometimes used a critical approach. The critical paradigm is also situated within a broad qualitative framework (Grbich, 1999). It is based upon the idea that a willingness to question social order has the potential to liberate and lead to social change (Higgs, 2001; Hoy & McCarthy, 1994). Although my research was not designed to effect change and therefore did not directly incorporate critical theory, I sometimes used a critical lens, particularly when addressing my second aim, which was to explore whether current healthcare interaction approaches are relevant and applicable to physiotherapy. Adopting a critical perspective within the interpretive paradigm allowed me to consider new possibilities regarding appropriate theory to support interactional aspects of physiotherapy practice.

Interpretivism is becoming an increasingly common paradigm in healthcare research (Cohen & Crabtree, 2008). As discussed in Chapter two, the physiotherapy profession has traditionally been heavily reliant on positivist research to inform practice (Petty et al., 2012a). Clinical aspects of physiotherapy, however, are often interpretivist in nature. The potential divide in conceptual framework between research and practice may be an issue for the physiotherapy profession, possibly contributing to the documented challenge of translating research into practice (Noronen & Wikstrom-Grotell, 1999; Simmonds, Derghazarian, & Vlaeyen, 2012). Recognizing that interpretive qualitative research is a potential medium through which to contribute knowledge applicable to professional practice, I sought to generate subjective, qualitative knowledge about the patient-physiotherapist interaction.

The conceptual framework of the research, interpretivism, informed the methodological frameworks. Ethnography and grounded theory were the methodological frameworks underpinning this research, both are key examples of research methodologies situated within the interpretive paradigm (Higgs, 2001). In the next section I consider ethnography and grounded theory as the methodologies that I drew upon to inform both my methods of data collection and analysis and my role as researcher.

Methodological frameworks

Ethnography

As the research was an exploration of the practices of physiotherapists and their patients as they interacted in the private practice setting, ethnography was an appropriate methodology (Murchison, 2010; Spradley, 1979). Drawing upon Spradley's (1980) description, I liken this research to a 'micro-ethnography' because, although the external environment and other members of the setting were considered, the ethnographic focus was almost entirely on the one-on-one interaction between patient and physiotherapist in the treatment room. I focussed on how patients and physiotherapists actually interact, including how they talk, what body language they use, how they position themselves, and the sequence of events that occur.

Participant observation is considered a central characteristic of ethnography that is essential for effective fieldwork (Fetterman, 1989; Hammersley & Atkinson, 1995). Authors have previously highlighted the lack of empirical observational evidence about communicative practice in physiotherapy (Opsommer & Schoeb, 2014; Parry, 2005, 2008; Thomson, 2008). In response, I used observation to understand and generate knowledge about what is actually occurring in practice. The limitation of interviews and surveys is that they only provide participants' perspectives of what is occurring in practice. As Thomson

(2008) attested, to understand how something occurs in practice it is not enough to ask the perspective of those involved, as often people do not actually do what they say they do. It is also acknowledged that tacit understandings will not be articulated in interviews (Charmaz, 2006). Making use of the observational elements of ethnographic methodology by including observations as a method of data collection is therefore a strength of this research.

Another characteristic of ethnography is relative immersion of the researcher in a particular context (Goodson & Vassar, 2011). Although in my research the observed context was more specific than traditional anthropological ethnographies, I spent time immersed in the field. Experiencing patient-physiotherapist interactions and subsequent time spent analyzing field notes and audio-recordings allowed me to develop the thick descriptions that are a central component to ethnographic methodology (Goodson & Vassar, 2011; Spradley, 1980). Ethnographies are often characterized by a multi-method approach, and my observations were augmented by interviews with both patient and physiotherapist participants to provide an understanding of the meanings and explanations for individuals' actions (Savage, 2000). As Barry (2002) suggests, these multiple methods produced a rich, complex picture of patient-physiotherapist interactions. Thus, although this research was not a traditional ethnography, many of the methods chosen were consistent with aspects of ethnographic methodology.

Grounded theory

Grounded theory is a common methodology in healthcare research. It is frequently used to generate theory that is grounded in and representative of the area being studied (Strauss & Corbin, 1990). The method of grounded theory was formulated by sociologists Glaser and Strauss (1967) and was refined and adapted by Strauss and Corbin (1990) and, more recently, by Charmaz (2006). Key methods of grounded theory continue to include: the use of theoretical

sampling, data collection and analysis occurring concurrently, the constant comparative method, and theory emerging directly from data via a process of inductive analysis (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Many of these methods align closely with the goals and methods of this research, thus aspects of grounded theory were adopted, largely to provide a consistent structure to my research process and to assist with the generation of conceptual understandings.

Although this was not a grounded theory study, many components of grounded theory methodology flavoured the research, particularly during data analysis. Charmaz (2006) describes a form of grounded theory ethnography that prioritizes the development of a conceptual understanding of a specific process or phenomenon. My research prioritized developing knowledge about the processes of communication involved in the patient-physiotherapist interaction and could therefore be termed a 'grounded theory ethnography'. Aspects of constant comparative methods, considered part of grounded theory, were included in the data collection and analysis components of this research as part of an iterative process (Charmaz, 2006; Glaser 1965). In addition, coding techniques used to derive theoretical explanations from both interview and observational data were central to the analysis process (Charmaz, 2006). Thus, the logic and back and forward processes described in grounded theory techniques were central to the methods of analysis incorporated in my enquiry.

Ethnographic and grounded theory methodologies as used in this research are compatible (Pettigrew, 2000). They can both be situated within the interpretive paradigm, have 'idealist' epistemologies, incorporate data collected in natural settings, and frequently include participant observations (Barnett-Page & Thomas, 2009; Pettigrew, 2000). Other research exploring human interactions has successfully incorporated features of both ethnography and grounded theory (for example, French & Williamson, 2016; Olthuis et al., 2014). Researchers have claimed that combining these two methods has generated detailed descriptions

as well as contributions to theory (French & Williamson, 2016; Pettigrew, 2000). Like these studies, the research presented in this thesis was neither a pure ethnography, nor a traditional grounded theory study. Instead, aspects of both methodologies were employed to optimize the research outcomes. Ethnography provided a framework within which to explore how patients and physiotherapists interact in private practice; grounded theory gave structure to the data collection and analysis process such that new ideas and conceptual understandings were generated.

Notes on my role as ethnographer

Pearsall (1965) described versions of the role of observer in behavioural research. These roles were termed 'complete observer', 'complete participant', 'observer-as-participant', and 'participant-as-observer'. During data collection I identified myself as observer-as-participant, but remained flexible in my role to allow me to maintain ethical awareness and respect for participants. As an observer-as-participant, observation was my main role during the observation data collection phase. This meant that I generally avoided involving myself with the affairs of the participants and 'going native' during the fieldwork (Pearsall, 1965). With this role I was able to remain objective but had reduced opportunity for verbal clarification of what I had observed (Byerly, 1969). Perhaps because of the confined space, it was, however, impossible for me to be a complete observer, and I did participate when it seemed appropriate.

My role as observer-as-participant was appropriate for the private practice setting of this research. In this setting patients frequently self-fund their treatments and have limited time with the physiotherapist who is on a tight schedule of patients for the day (Hudon et al., 2015). I was mindful that it was a privilege to observe these interactions and did not want to detract from the quality and amount of treatment that patients were receiving. Nor did I want to add increased stress to an already busy day for the physiotherapists. These

factors aided my decision to rarely participate actively in the sessions that I was observing.

Capturing typical interactions between patients and physiotherapists with minimal disruption was important, and another reason why I deliberately chose to be an observer-as-participant. I was mindful that my presence would alter the dynamic between patient and physiotherapist, particularly if I were participating in the interaction. I recognized that while some alterations to practice might be inevitable, changes to typical interactions would reduce the trustworthiness or truthfulness of the data (Cohen & Crabtree, 2008). I therefore chose a reflexive, observer-as-participant stance to capture how patient-physiotherapist interactions in private practice actually occur (Doyle, 2013; Finlay, 1998).

To highlight my role as observer-as-participant, I reproduce the following memo from my research diary.

Physios seemed relatively unfazed by my presence. One of them tried to catch my eye a couple of times to smile during sessions. Mostly I tried not to make contact. Although I am in the room, I am desperate for this impact to be minimal.

Most patients suitably ignored me, but once I was sitting in the patient's line of vision for the subjective assessment and he tried to make eye contact with me too (every time the physiotherapist asked him a question). I looked away gently so that he felt comfortable only communicating with the physio.

This memo explains how I was conscious of my role, and although I wanted to minimize the impact my presence had on the interaction, I was conscious of the need to be polite and appropriate in my actions. Inevitably there were occasions when I became a participant-as-observer in the interaction. Such participant-as-observer occurrences were initiated by participants. For example, patient participants often asked questions about the research when the physiotherapist

left the room. I carefully considered all of these interactions with the participants and used reflexivity to assist in planning for the next time such an occasion occurred.

As a gauge of my success in maintaining my role as observer-as-participant, I asked questions during interviews with both patient and physiotherapist participants about whether the interaction was different as a result of my presence. Physiotherapists unanimously reported that they were unfazed by my presence, but some patient participants commented that their physiotherapist seemed more formal or structured than usual. Patient participant Peter (pseudonym) who was a frequent attender of physiotherapy in private practice, commented:

It was interesting because the dynamic was different because you were there.... He was just a little bit more robotic, did a few more things that just, to me, seemed like a bit of a waste of time, that was just a bit 'I'd better just do this because,' a bit more textbook perhaps, than more delving... than he might have done before... having been to the other sessions with him.

(Peter, patient participant)

Despite my conscious consideration and methodological choices, the patient-physiotherapist interactions were inevitably altered to some degree by my presence.

An interesting addition to this discussion about my role as observer is that I have been a participant in this particular interaction many times. Prior to commencing my PhD I worked for seven years as a physiotherapist in private practice settings in Darwin, country Victoria, and in London. During the duration of the PhD I have also been a patient of a number of physiotherapists in private practice. I have therefore experienced this type of interaction as both a

physiotherapist and a patient. While certainly not part of my official data collection, these participant experiences inevitably shaped the results of this research.

Despite not identifying as a participant observer and participating in patient-physiotherapist interactions, my experiences, approach, and commitment to 'being there' as part of the interactions I observed captures the essence of what it means to be an ethnographer (Murchison, 2010, p. 12). My role as observer-as-participant was therefore ethically and methodologically appropriate for this micro-ethnography in the physiotherapy private practice setting.

Methods: Data collection

Introduction to methods

In this section I present methods of data collection and analysis underneath two subheadings. Although these methods are presented chronologically, it is important to acknowledge that data collection and analysis actually occurred concurrently and in a cyclical manner to reflect the ethnographic principles of immersion and the constant comparative aspects of grounded theory (Charmaz, 2006; Goodson & Vassar, 2011). Data collection and analysis continued iteratively until no further ideas or themes were generated from additional data. The concept of data saturation therefore supported the cessation of data collection (Kisely & Kendall, 2011; Liamputtong, 2009).

Recruitment and sampling

The research recruitment plan had four stages. The first stage was to contact managers of private practices by phone using publically available contact details and to send information to those who expressed interest in participation. The second stage, following verbal consent of the practice manager, was to visit the

private physiotherapy practice to outline the research to potential physiotherapist participants and to gain their informed consent to participate in observations and an interview. At this visit, physiotherapists and administrative staff were briefed about the process of recruiting patient participants and provided with an information sheet, plain language statements, and consent forms. The third stage involved the recruitment of patient participants to be observed in their interactions with physiotherapists; the fourth stage was gaining further consent from patient participants willing to undertake an interview in addition to being observed.

I sought to recruit participants who could provide typical patient-physiotherapist interactions in private practice. To achieve this, two key aspects of private practices were considered before contact was made. The first consideration was whether the practice had a number of physiotherapists of different genders and levels of experience as potential participants. Second, I ensured that practices I contacted had clientele that varied in factors such as reasons for seeking treatment, funding sources, ethnic backgrounds, and age groups. As an example, it would have been undesirable to have a practice with only male physiotherapists who mostly treated younger people with sports injuries. Although I was aware that the data collected could never be representative of all different scenarios, I wanted to incorporate variation in participants and observe interactions that would provide a range of experiences of interaction.

Recruitment relied on the participation of two private practices as the research settings, and the participants became a purposive convenience sample of physiotherapists and patients working at or attending these practices. I decided to incorporate two separate private practices as the settings to provide some variation, yet also allow the rich, detailed data that I required. Despite months of planning, recruiting physiotherapy practice managers and their practices to participate in this research was difficult as all contacted practices declined

participation, mostly stating that they were too busy to incorporate research into their daily activities. The participants became a purposive convenience sample because after several months without recruitment, I used personal contacts. I term the recruited practices 'Practice A' and 'Practice B'. The manager of Practice A and I had studied together in the past. Practice B was incorporated into the research after a fortuitous conversation at a physiotherapy conference with one of the physiotherapists who worked there. Using this convenience sampling technique meant that there was a probable participant bias towards physiotherapists who were interested in interaction and supportive of research.

The outlined recruitment process occurred in phases relative to collection of 'data sets'. A 'data set' comprised data associated with each physiotherapist participant: five to seven observed interactions with patients, the physiotherapist interview, and interviews with associated patients. There were gaps between the recruitment of each physiotherapist and the collection of each data 'set' to allow time for analysis and incorporation of emerging ideas into the next phase of data collection. There was also a gap of six months between recruitment of Practice A and Practice B. Analysis occurred continuously during and between each phase of data collection.

The participants

The participants were a purposive convenience sample, selected as informants to assist me to answer my research question (Liamputtong, 2009). In total, there were 9 physiotherapist participants and 52 patient participants. The 4 male and 5 female physiotherapist participants were each employed at Practice A or Practice B, had between 1.5 and 21 years of practice experience, and had varying postgraduate qualifications. Table 1 provides further information about these physiotherapists and their involvement in the research. All participant names are written as pseudonyms. Note that Caroline, an experienced physiotherapist who specifically treated women with chronic pelvic pain, had difficulties

recruiting patients willing to be observed due to the sensitive nature of her consultations and interventions. She therefore participated in an interview only.

Table 1: Characteristics of physiotherapist participants

Pseudonym name (Gender)	Years of practice since graduation	Postgraduate qualifications (Field of physiotherapy)	Number of consultations observed (Initial consultations/follow-up consultations)
Sharon (Female)	3.5	Clinical Masters (Musculoskeletal)	7 (2/5)
Tommy (Male)	8	Clinical Masters (Musculoskeletal) Clinical Masters (Sports) Clinical Doctorate	7 (2/5)
Simone (Female)	8		6 (1/5)
Kate (Female)	21	Clinical Masters (Musculoskeletal) PhD	6 (1/5)
Clint (Male)	20	Clinical Masters (Neurological) PhD candidate	5 (1/4)
Lachlan (Male)	1.5		7 (1/6)
James (Male)	5	Postgraduate Certificate (Sports)	7 (1/6)
Donna (Female)	19	Postgraduate Certificate (Continence and pelvic floor)	7 (3/4)
Caroline (Female)	20	Postgraduate Certificate (Continence and pelvic floor)	0

The two groups of patient participants in this research were those who were observed in their interactions with their physiotherapist and those who were observed and also participated in an interview. The 15 male and 37 female patient participants ranged in age from approximately 20 to 70 years. They sought treatment for typical complaints in private practice including: neck and back pain (25), knee pain (6), work-related injuries (4), sports injuries (4), balance and neurological conditions (5), women's health concerns (3), chest treatment (1), and other areas of pain (4). All patient participants spoke English sufficiently well to provide informed consent, but many had different cultural backgrounds such as Chinese, Indian, and Malay. Table 2 includes more detail about the subgroup of patient participants who were observed and later interviewed. Unexpectedly, all interviewed patient participants except Jocelyn had previously consulted a physiotherapist and were willing and able to compare their experiences of interactions with their current and past physiotherapists during their interviews.

Table 2: Characteristics of interviewed patient participants

Pseudonym name (Gender)	Age (Approx.)	Reason for seeking treatment	Funding source for treatment	Number of sessions attended with the physiotherapist
Robert (Male)	50	Ongoing neck and back pain	Motor Vehicle Accident Insurance	2 (Sharon)
Jacqui (Female)	25	Knee pain	Self-funded	10 (Tommy)
Margaret (Female)	60	Knee pain	Self-funded	6 (Simone)
Robyn (Female)	45	Chronic regional pain syndrome in foot	Worker's Compensation Insurance	4 (Clint)
Simon (Male)	55	Lower back pain	Self-funded	8 (James)
Peter (Male)	40	Lower back and shoulder pain	Self-funded	4 (James)
Melanie (Female)	25	Knee pain	Self-funded	3 (James)
Laura (Female)	35	Neck pain and headaches	Self-funded	20 (Donna)
Jocelyn (Female)	60	Knee pain	Medicare funded	1 (Simone)

The settings

The research settings were two private physiotherapy practices in metropolitan Melbourne, Australia: Practice A and Practice B. Although I wrote notes including sketches about the entire physical environments of both of these practices, this

section concentrates on describing the treatment rooms themselves. This is fitting for a micro-ethnography. My descriptions are provided to assist the reader to understand the context of the private practice environment.

Practice A was founded and run by Tommy, a highly qualified and enthusiastic principal physiotherapist. Located in the outer eastern suburbs of Melbourne, Practice A had two treatment rooms off one waiting room area, all attached to Tommy's private home. In total, six physiotherapists were employed full or part time. In addition to the main practice site, the business also incorporated 'satellite' clinics: treatment rooms situated within medical clinics in the surrounding suburbs. I observed Simone interacting with patients at one of these satellite clinics. Sharon and Tommy were also physiotherapist participants from Practice A, both observed at the main practice site. The physiotherapists organized appointments and payments themselves because the practice did not employ a dedicated administration person.

Practice B, located in the inner north eastern suburbs of Melbourne, was larger and had been established longer than Practice A. Caroline, Clint, and Kate, three well-qualified physiotherapists with many years of experience and expertise between them were the practice principals. The building was a long, narrow, terrace. Four treatment rooms led off one long hallway with a large reception area at the front and a small kitchen and bathroom at the back. I observed Kate, Clint, Lachlan, James, and Donna interacting with patients in treatment rooms at Practice B. A number of other physiotherapists were employed at Practice B either part or fulltime, some of whom I met and others who were on holidays or did not work on the days that I was present as an observer.

Physiotherapy treatment rooms in both practices had many similar features. Each included: a plinth with a single pillow and towels; two patient chairs; a swivel chair for the physiotherapist; a desk with a computer; a sink; some shelves or cupboards for massage creams, hand sanitiser, and other equipment;

a carpeted floor; and anatomical images on the wall. All the rooms in which I observed interactions were air-conditioned to an appropriate or slightly cool temperature, had a faint scent of massage cream, and were about 2.5 x 3 metres in size. As a point of difference, Practice B had a mint green feature wall in each room that was less clinical in that it also incorporated a framed photograph of a person from Nepal. Figures 1 and 2 provide sketches of the layout of two of these treatment rooms: one from the Practice A satellite clinic I attended and one from Practice B.

Figure 1: Sketch of the satellite clinic treatment room, Practice A

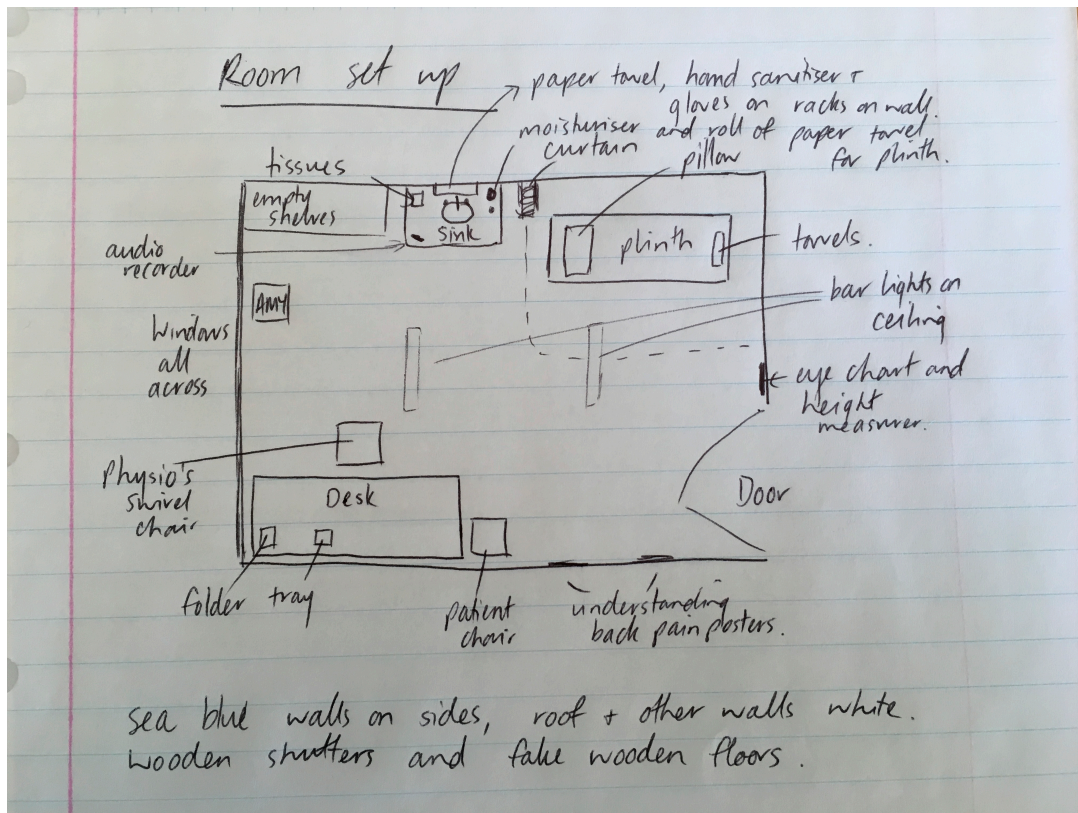
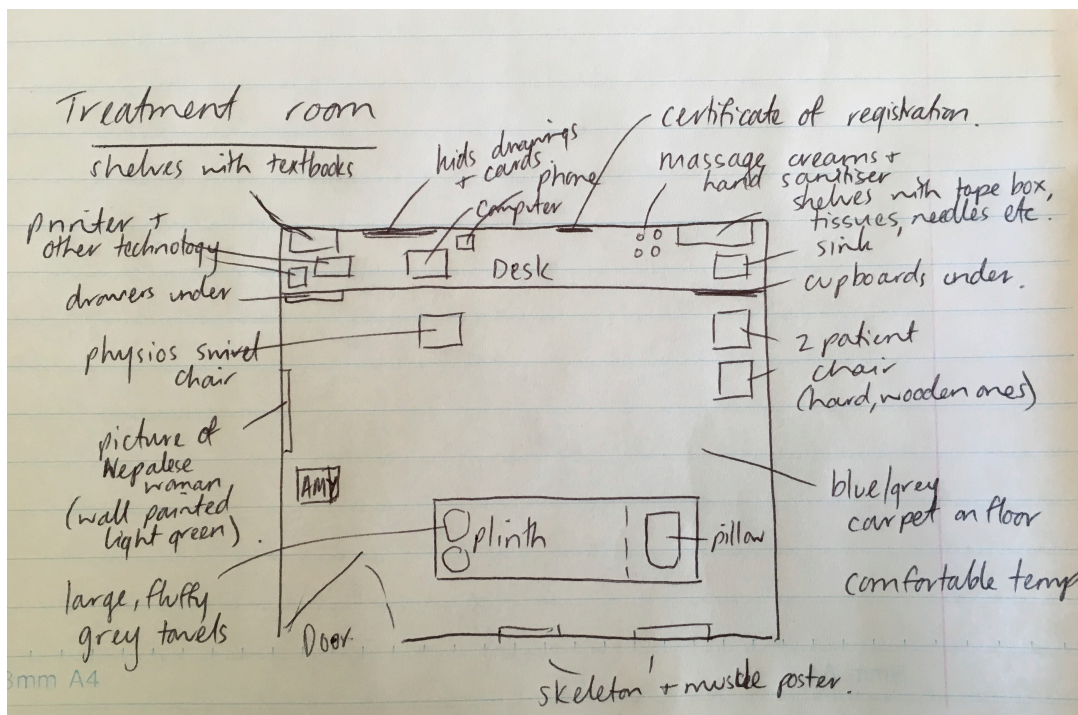


Figure 2: Sketch of a typical treatment room, Practice B



My previous experiences working in private practices in Australia and the United Kingdom would suggest that these treatment rooms and wider practice environments were representative of western physiotherapy practices. Equally, other descriptions of aspects of physiotherapy private practices in Denmark and Canada provide similar details about this context (Hudon et al., 2015; Praestegaard et al., 2013). In Australia, most private practices are set up and run by a principal physiotherapist (or a group of physiotherapists) and incorporate a reception and waiting area as well as a number of treatment rooms. Another type of private physiotherapy practice common in Australia is one that is part of a corporate chain of practices each with its own practice manager. I would have appreciated insights into the culture of interactions within a corporate system but unfortunately the managers of corporate chain private practices that I contacted declined to participate.

Fieldwork: observations

Observations were central to the data collection. Their purpose was to capture and describe how patients and physiotherapists interacted with each other. In this section I detail the observation data collection methods, justify my choice to audio-record consultations, explain the process of generating field notes, and detail my role and impact as the observer.

After physiotherapists consented to participate, I arranged a day to observe them interacting with their patients. Patients observed in consultations with physiotherapists were a convenience sample of those seeing the physiotherapist on my observing day and who had consented to participate. The 52 consultations that I observed lasted between 20 minutes and an hour, and each involved a different patient. With each physiotherapist I observed 5 or more consultations, including at least one initial consultation (refer to Table 1 for further detail).

I gave careful consideration to the choices between using video-recording, being physically present to undertake the observations, or a combination of both. Although video-recording has specific merits, particularly with regard to recalling non-verbal components of the interaction, I chose to audio-record and be present as an observer for three reasons. First, undertaking observations as a physically present observer is consistent with an ethnographic methodology (Spradley, 1980; Thomson, 2011). Second, I wanted to understand the nuances and capture the 'essence' of the interaction beyond that obtained by a two-dimensional video camera. Thomson (2008) criticized physiotherapy interaction research that analyzed video-recordings because she perceived that video-recordings failed to capture the true nature of the practice interaction. Third, it has been noted in physiotherapy communication research that patients are reluctant to undress and that physiotherapists' empathic behaviours are reduced in the presence of a video camera (Roberts & Bucksey, 2007; Roberts et al., 2013). These sensitivities make the use of even a small video-recorder while observing more likely to make patient participants feel uncomfortable. The likely impact on the interaction between patient and physiotherapist and possible subsequent recruitment challenges were both barriers to video-recording treatment sessions. Thus, I believed that being an observer was essential to ensure methodological consistency as well as to minimize the impact of collecting observational data on the patient-physiotherapist interactions themselves.

As I observed patient-physiotherapist interactions, I collected field notes and audio-recordings as data. As Edwards and colleagues (2004) suggested, audio-recordings meant that I could re-listen to the verbal components at a later time, allowing me to acutely observe the non-verbal components of the interaction. Field notes were written to create an ethnographic record incorporating clear descriptions of the activities, processes, and contexts (Spradley, 1980). During observations I jotted down words that would later remind me of the details of the interaction. For example, I wrote about non-verbal happenings such as facial

expressions, body language, positioning in the room, touch used, and actions that occurred. Field notes highlighted significant moments and described the feelings I experienced in the room. Shortly after, I added to the notes more formally and wrote personal reflections separately in my research diary (Thomson, 2011). During analysis, these field notes were collated with transcripts from audio-recordings to provide detailed data about patient-physiotherapist interactions.

I was aware that as the observer my presence potentially impacted on the interactions between patients and physiotherapists and the data that I generated. I mostly observed from a static position, usually seated in a chair in a discrete part of the small treatment room (see Figures 1 and 2 for examples of my location). Although a static position sometimes reduced my ability to view different aspects of the interaction, it was likely to impact less on the naturally occurring interaction between patient and physiotherapist. Edwards (2000) observed physiotherapy practice and explained how participants relaxed in his presence with time. In addition to deciding to observe rather than video-record, I also chose to observe physiotherapist participants for a full day in the hope that they would be busy with their usual tasks and become comfortable with my presence, reducing my impact as an observer. In addition, I was aware that as the researcher my knowledge and biases would be evident in my field notes. I entered the field as an observer with background knowledge from the literature that assisted me to direct my focus upon features of interaction. I was, however, aware that I needed to be able to explore and experience the interactions without preconceived ideas (Grbich, 1999). Finding a balance that involved being guided by previous knowledge yet remaining open was important.

Fieldwork: interviews with patient and physiotherapist participants

I undertook in-depth interviews to collect data about the perspectives of both patients and physiotherapists as participants in the interaction. These interviews were audio-recorded and held after observations had been undertaken at the

time and location of each participant's choice. Flexible interview guides were used to support the inclusion of relevant topics and interviews were supplemented by a graphic elicitation technique. All 9 physiotherapist participants and 9 patient participants were interviewed (see Tables 1 and 2). Interviews with physiotherapist participants lasted between 45 minutes and 2 hours, and those with patient participants lasted between 25 and 45 minutes.

I deliberately chose to undertake formal interviews as opposed to the more common informal interviewing that often forms part of an ethnography (Grbich, 1999). In part this was necessary because obtaining spontaneous interview opportunities in the private practice setting itself was limited. It was also particularly important to interview patient participants in a place of their choosing to allow them to feel relaxed and open to expressing their opinions. This may not have been possible in the private practices that were the physiotherapists' domain. Patient participants chose either their homes or workplaces as suitable locations. Physiotherapist participant interviews were all undertaken in the physiotherapy practices, either during the physiotherapists' lunch breaks or at the end of the day. The interviews did, however, achieve openness consistent with ethnographic interviews because I had established a relationship with participants prior to the interview, particularly with physiotherapist participants (Thomson, 2011).

Using Liamputtong's (2009) suggestions, I prepared interview guides for both patient and physiotherapist participant interviews (see Appendix C), and a list of interview topics and example questions formed part of the information sent to potential participants. I used the interview guides as prompts during interviews. Questions arising from my field notes that related to the specific interactions that I observed were also included in each individual interview. As data collection progressed, questions and topics changed in response to emerging codes and elements from data analysis. For example, questions about touch were

incorporated after early analysis. In my field notes I wrote as extra questions for the interviews:

Physiotherapists – talk to me about how you use touch in interactions with your patients. What is it used for?

Patients – talk to me about the use of touch in your sessions with the physio. What does touch mean to you in this context?

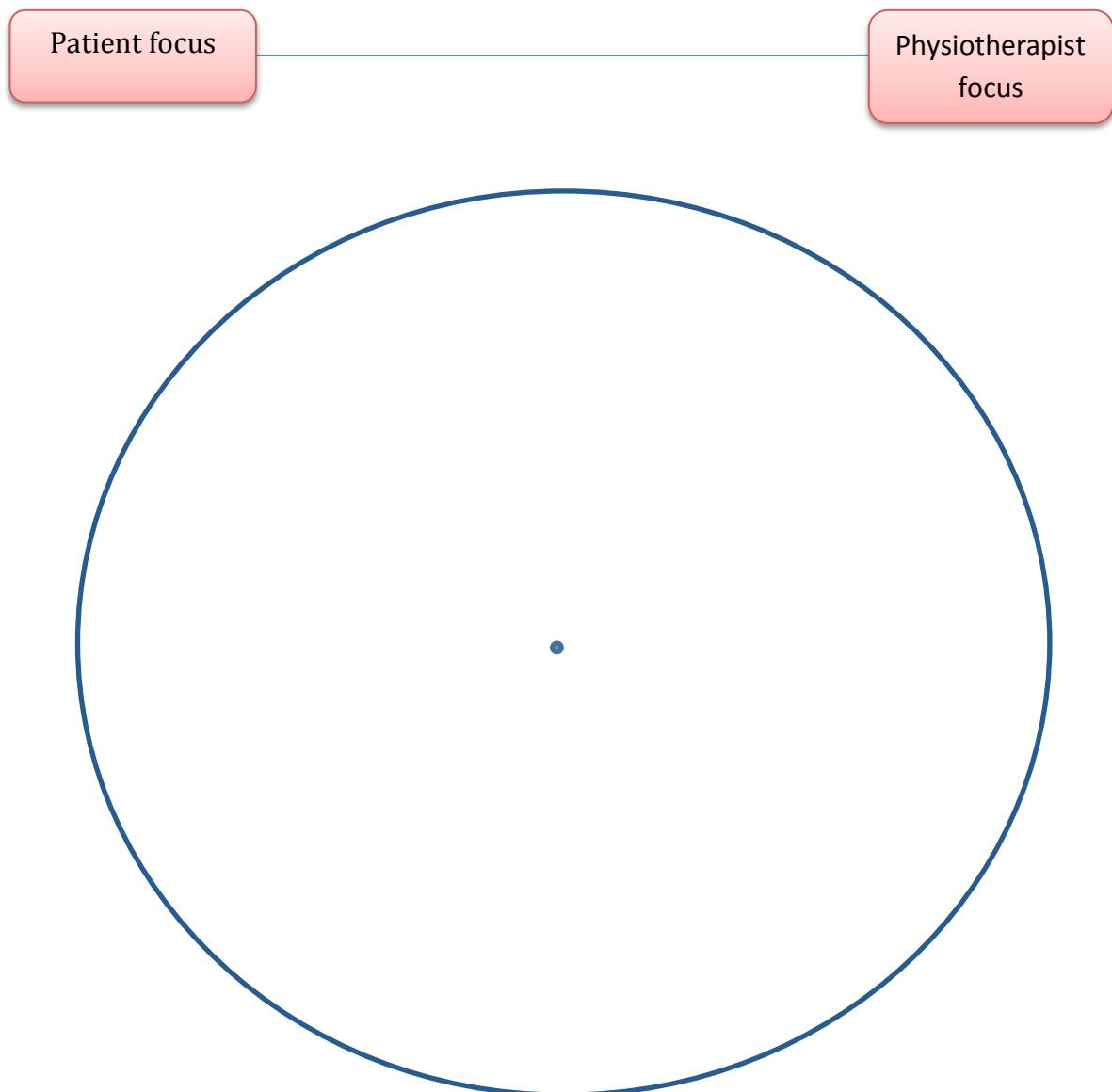
I was, however, mindful to ask broad, open-ended questions, and to use silence and active listening where required (Liamputtong, 2009). Specific questions such as those about touch were often left until the end of the interview as I preferred participants to initiate topics and ideas themselves and wanted to avoid leading the participants' answers.

A form of graphic elicitation data was also obtained during interviews and is deemed part of the interview data. Defined as the use of diagrams or drawings to convey thoughts, graphic elicitation techniques have been described as a useful adjunct to interviews in qualitative research (Bagnoli, 2009; Copeland & Agosto, 2012; Crilly, Blackwell, & Clarkson, 2006). As shown in Figure 3 (and also in Appendix C), I incorporated diagrams into the interviews for participants to complete; these diagrams comprised a spectrum and a circle. These graphic elicitation components were incorporated into the interviews as another way of eliciting information from participants with the aim to stimulate ideas by encouraging participants to reflect on their interactions in different ways (Bagnoli, 2009; Crilly et al., 2006; Harper, 2002). The physiotherapist participants, in particular, embraced this part of their interviews and valuable data was obtained.

Figure 3: Graphic elicitation diagrams for both physiotherapist and patient interviews

Physiotherapist participants

Please place a mark on this spectrum where you feel the focus lies during your treatment sessions:



Consider your approach to interacting with your patients. What do you focus on?
Please add the elements that you consider important to this pie chart.

The patient-physiotherapist interaction



Patient participants

Please place a mark on the above diagram where you feel your session with the physiotherapist was located on this spectrum. Also place a mark where you feel it should be located (if different).

Please also draw or write anything else that comes to mind with regard to components of the communication or interaction between yourself and the physiotherapist.

In summary, this section has outlined the methods of data collection including recruitment, participants, and settings, as well as the processes of both observations and interviews. The methods of data collection enabled me to capture a comprehensive picture of the patient-physiotherapist interaction consistent with a micro-ethnography methodology. Employing both observations and interviews allowed me to consider and explore what actually occurred in practice as well as the participants' perspectives of what occurred in their interactions. Such multiple methods have been deemed to provide a rich, complex picture (Barry, 2002), and also serve as a form of data triangulation (Creswell, 1998; Flick, 1992; Morse, 2001). The data triangulation and subsequent layers of meaning and depth of understanding are considered strengths of this research that increase the trustworthiness of my findings.

Methods: Data analysis

To achieve my two research aims, two separate parts of data analysis were used. The first part was analysis of the empirical data to achieve the first aim and answer the research question: 'how do patients and physiotherapists interact in private practice?' The second component addressed the second research aim of whether and how reported approaches to healthcare interaction correlate to patient-physiotherapist interactions in private physiotherapy practice. This was achieved by comparing the empirical research findings with features of established approaches to healthcare interaction described in the literature and summarized in Chapter two.

Inductive analysis to derive empirical findings from the data

Aligning with the aims of the research, the first component of data analysis was inductive and generative as I was seeking to inductively generate understandings about how patients and physiotherapists interact (Braun & Clarke, 2006; Goetz & LeCompte, 1981). Inductive analysis is a data-driven

process of coding and developing findings where the researcher does not try to fit data into pre-existing coding frames or analytic preconceptions (Braun & Clarke, 2006). To achieve this inductive analysis, qualitative analysis incorporating methods of constructing grounded theory described by Charmaz (2006) as well as aspects of thematic analysis explained by Braun and Clarke (2006) were used.

Principles of constant comparative methods underpinned the process of analysis (Charmaz, 2006). Although less systematic than the formal constant comparative method (Glaser, 1965), I undertook data analysis iteratively in many stages as a cyclical approach. Data analysis permeated the entire research process as I sought to make connections between and within data. Within this constant comparative framework, the analysis of empirical data consisted of four stages: transcription, data coding, memo-writing, and concept mapping. I stress that although these steps are described here as a linear, chronological process, they actually occurred as a recursive process in a back and forth manner (Braun & Clarke, 2006).

My first three stages of analysis generated categories that I term 'elements' of interaction. Each element describes an aspect of communication or the impact of an aspect of communication on the patient-physiotherapist interaction. For example, the element 'using biomedical terminology' is an aspect of communication, and the element 'conveying clinical competence' describes the impact of aspects of communication. Via concept mapping these elements were then incorporated into two central themes as the fourth stage of analysis. Chapters four and five each present a central theme that encompasses and is substantiated by many elements of interaction derived from each data source.

There were subtle variations in how I analyzed the different data sources within my analytic framework. Interview data were mainly analyzed through the first two phases, corresponding to the thematic analysis process described by Braun

and Clarke (2006). In contrast, analysis of observational data incorporated more memo-writing. Although I was constantly referring back and forth between data, I largely analyzed the three sources of data separately and then combined them as part of concept mapping. This separation of observational, patient interview, and physiotherapist interview data acknowledges that there is not one reality for how patients and physiotherapists interact. Each perspective, the observer, patient, and physiotherapist, provided a slightly different view of important factors related to interaction and the interaction itself. Keeping these perspectives separate, and then later combining them, provided triangulation of data sources that gave strength to the themes that encompassed findings from all three data sources (Creswell, 1998; Flick, 1992; Morse, 2001). Moreover, analyzing and presenting data as three independent sources makes it easier to understand the derivation of the findings presented in Chapters four and five.

I analyzed graphic elicitation data in conjunction with other data. The verbal explanations that participants provided about why they placed the mark on the spectrum where they did were transcribed and incorporated into interview data. The circle part of the physiotherapist participant graphic elicitation process included words and phrases written by physiotherapists as well as some verbal explanations. Again, I transcribed and analyzed verbal comments made while completing this graphic elicitation task as part of the interview data. In addition, I extracted, collated, and analyzed the written words and phrases into focussed codes that were later combined with other focussed codes from physiotherapist interview data and incorporated into elements of interaction derived from physiotherapist participant interviews.

Although I undertook all data collection and analysis myself, my supervisors each independently listened to a small sample of audio-recordings and their associated transcriptions and undertook some independent analyses. We met to discuss codes developed from the data to achieve depth of understandings and to add different interpretations and perspectives, thereby reducing the impact of

my personal biases. Some consider the employment of different researchers to be another form of triangulation (Flick, 1992; Johnson & Waterfield, 2004). This method of triangulation was incorporated to increase the 'completeness' of the elements of interaction and overarching themes developed during the analysis process.

Transcription and data collation

The initial formal phase of analysis included transcription and revision of field notes. This phase involved repeatedly listening to audio-recordings, adding to field notes, and transcribing all interviews and sections of observational audio-recordings verbatim, as well as re-reading data and jotting down initial ideas (Braun & Clarke, 2006). Due to the number of utterances involved, transcription of the observational audio-recordings was particularly time consuming, so only important sequences were transcribed and collated with the associated field notes.

The process of repeated listening, note taking, and transcribing enabled me to become absorbed and immersed in the data (Holloway & Wheeler, 2010). Familiarization and immersion in the data generated ideas that were recorded in my field notes and later became part of memo-writing (Charmaz, 2006). Having an intimate familiarity with interactions between patients and physiotherapists was an important part of data collection and analysis because it is associated with achieving in-depth knowledge, but also because it is a strategy for revealing researcher preconceptions (Charmaz, 2006). Achieving familiarization through the transcription, data collation, and initial coding processes, assisted me to challenge my preconceptions, move beyond aspects that I took for granted, and allow consideration for the participants' interpretive views.

Data coding

I systematically applied two processes of coding to field notes and transcriptions: initial coding and focussed coding. Initial coding followed the principles described by Charmaz (2006) and involved labelling lines and segments of data using simple precise codes that remained close to the data. Specifically, Charmaz's (2006) description of line-by-line coding was used for interview data; observational data were coded by comparing incidents transcribed from audio-recordings or recorded in field notes. As Charmaz (2006) suggests, line-by-line coding was not readily applicable to observational data, partly because my own words were already present in the field notes. The labels used as codes were driven by the data and each identified a feature in the data that provided some insight into how patients and physiotherapists were interacting (Braun & Clarke, 2006). I performed this coding process manually using highlighting and coloured 'post-it' notes. The initial coding process facilitated the beginnings of pattern generation, and revealed contrasts in my data that enlightened my view of the patient-physiotherapist interaction and assisted to inform subsequent data collection.

Following initial coding, I employed a process of focussed coding to synthesize the data (Charmaz, 2006). The focussed coding was more conceptual than the initial coding. During this phase of analysis I started to consider the relationships between codes and adjusted or combined initial codes to categorize the data. Constant comparison continued and this phase of analysis resulted in the development of focussed codes that later became elements of interaction presented in my findings.

Memo-writing

To explore, refine, and portray the specifics of codes that became 'elements' of interaction derived from the data, I undertook a process of memo-writing. My

memo-writing also largely followed instructions and suggestions provided by Charmaz (2006). Early in the analysis process I chose codes that seemed significant and wrote descriptive pieces to explore and detail their specifics. As Charmaz (2006) suggests, I used basic questions to interrogate the data and to direct some of my memo-writing; these were particularly relevant and useful for observational data. Most of these questions were broad and generic such as 'what are the people doing?' Other questions were roughly informed by interaction theory and included: 'what does the patient do? (what is the patient's role?); 'what is the behaviour of the physiotherapist during the interaction?'; 'how does the physiotherapist understand the patient?'; and 'what modes of communication are used?' Writing memos not only added clarity and connections, but also pointed to gaps and provided directions for subsequent data collection and ongoing analysis.

In later memo-writing I attempted to understand the processes and meanings behind individual codes and elements that I had developed through initial and focussed coding. During the continual writing process, I formed clear descriptions for codes and included quotations from raw data into memos to substantiate each description and my analytic claims. It was largely through memo-writing that focussed codes became elements of the patient-physiotherapist interaction that I present in Chapters four and five. In addition, these memos often formed the basis of the descriptions provided in the results chapters.

Creating concept maps

Following the generation of elements of interaction, I drew concept maps. The idea of using concept maps, as described by Novak and Gowin (1985), was to organize the data and assist with establishing relationships between elements of interaction that had emerged through analysis (Brightman, 2003). Charmaz (2006) describes a similar process termed 'diagramming' that provides a visual

representation of the connections between codes and categories derived from the data. Focussed codes, elements, and ideas from memo-writing came together through links in the concept maps. At first I created three separate concept maps, one for each data source. Later concept maps combined findings from all three data sources, and highlighted the two central themes derived from all data. Elements of patient-physiotherapist interactions were further refined as a result of the connections and cross-links demonstrated through the concept maps. The connections provided new insights into the data (Brightman, 2003), highlighting the key themes pertinent to patient-physiotherapist interactions. These central themes frame the results presented in Chapters four and five.

Comparing empirical findings with established approaches

The second part of analysis occurred once the empirical research results had emerged through the four stages of analysis described. In this analysis I compared the inductively derived elements of interaction with features of established approaches to healthcare interaction. I first revised the literature and familiarized myself with descriptions of practitioner-centred, biomedical, patient-centred, and biopsychosocial approaches, recording specific features of each of these approaches in a table. I then carefully compared each of the elements of interaction derived from my empirical analysis with these tabulated features of approaches to healthcare interaction to evaluate their similarities and differences. Planning and writing my published article 'Exploring healthcare communication models in private physiotherapy practice' (see Appendix A) assisted with this process.

The comparative analysis was designed to provide insight into the relevance of promoted approaches of healthcare interaction to actual patient-physiotherapist interactions in the private practice setting. The process was challenging because the inductively derived elements of interaction did not match exactly with the

features of healthcare interaction approaches. The results of this second part of analysis are reported and discussed at the end of Chapter five.

Ethical considerations, my role, and reflexivity

The research was granted ethics approval by the Human Research Ethics Subcommittee at the University of Melbourne, ethics ID: 1238974. The process of gaining ethics approval was instrumental in my research design as it provided a structured approach to developing methods that recognized and acknowledged the ethical components of the project. Three key ethical considerations were particularly important: ensuring confidentiality, achieving informed consent, and managing participant misconceptions. The final section of my methods chapter outlines the ethical considerations and relates them to reflexivity and to the implications of my role as researcher.

Ensuring confidentiality

I was mindful of maintaining the confidentiality of all participants in this research to ensure respect for their autonomy (Beauchamp & Childress, 2001). However, due to their small number, my primary concern was ensuring the confidentiality of physiotherapist participants. It was possible that other physiotherapists, particularly those employed within the participating practices, would guess the names of those involved in the project. As an example, despite using pseudonyms, the details about physiotherapist participants' clinical experience and postgraduate qualifications in Table 1 may have revealed the participants' identities to those working at the practices. Information and demographics about participants, however, needed to be included in both the thesis and the research reports for the reader to make meaningful conclusions about the results. In contrast, patient participants' identities were confidential to all but the administration staff and treating physiotherapist. There were also

more patient participants, reducing the likelihood that they or their data would be recognizable.

To minimize the risk of confidentiality being breached, discussions and reminders about the importance of confidentiality were undertaken with consenting practice managers and, where possible, with their administration and other physiotherapy staff. I also employed strategies such as the use of pseudonyms and secure data storage throughout the research process to conceal the identities of participants (Liamputtong, 2009). In short, the research process was carefully designed to maximize confidentiality and reduce the risk of participants and their data being recognized.

The process of obtaining informed consent

Grounded in the right to self-determination, attaining informed consent is an important part of recruiting research participants (Miller & Boulton, 2007). Informed consent involves providing information to participants about the research, including risks and benefits, and ensuring that they have understood and made a voluntary decision to participate (Emanuel, Wendler, & Grady, 2000). All participants in this research were over 18 and able to read and understand English such that informed consent could be achieved. Plain language statements were provided and written consent was gained (see Appendix D).

I personally spoke with potential physiotherapist participants who each had time to read and understand the plain language statement as well as ask any questions of me about the research. They were therefore able to provide their informed consent. Gaining informed consent from patient participants, however, was a considerable challenge. For confidentiality reasons it was inappropriate for me to contact potential patient participants personally. So to gain informed consent, I relied on administration staff and the treating physiotherapist to

provide patients with verbal information and a plain language statement about the research. I encouraged recruiters to contact potential patient participants prior to the day on which I would be present to observe interactions. I also provided a clear page outlining the information that administration or physiotherapy staff needed to provide to potential patient participants (see Appendix E). Unfortunately this information was often lost in the busy lives of those recruiting.

Time limitations and multiple other responsibilities for administration staff and physiotherapists meant that potential patient participants were often only given very brief summaries about the research before being asked to sign the consent form. This meant that often information was not adequately conveyed to achieve informed consent. Whenever I happened to be present during the provision of information to potential patient participants I tried to distance myself to remove pressure for the patients to consent. If they did consent, however, I often quickly provided some further information, particularly with regard to the audio-recording component, to ensure that they were appropriately informed and were truly willing to participate. Another concern that I repeatedly explained was the possibility of patients feeling coerced to participate because their treating physiotherapist was a participant.

My research diary provides some insights into the challenges associated with the process:

The patient recruitment process remains difficult. One of the physios had given her patients information the week before which was very helpful, as them having time to read the PLS [plain language statement] meant I achieved proper informed consent. Overall, I felt much happier than on previous occasions when the physio simply said: 'she's a researcher, do you mind if she sits in? Please sign here' (despite me explaining it was important to provide more detail).

I usually interrupted at this point to give brief information and explain that I needed to audio-record. I made a real effort to ensure all patients left with a PLS (and therefore my details) and knew to contact me if they had concerns.

My interruptions were to ensure that key points were conveyed to achieve consent that was informed. Throughout the process I was mindful of obtaining a balance between gaining informed consent from patient participants, ensuring that patient participants did not feel coerced to participate, yet also minimizing disruption to the physiotherapist participant's daily schedule.

Achieving confidentiality and informed consent relied on sound research process and careful consideration of the research plan. In addition, these and other ethical considerations during the research were intricately linked with my role as the researcher. How I portrayed myself impacted on participants' perceptions and precipitated some subsequent ethical challenges that I will discuss in the next section.

My role as researcher and physiotherapist

Having a clinical background as a physiotherapist, I found transitioning to the role of researcher challenging. As a researcher and a physiotherapist I held both a 'dual role' and was an 'insider researcher' (Asselin, 2003; King & Churchill, 2008). For this research I perceived my role as that of a researcher. However, I was already a member, and assimilated into the culture, of the physiotherapy profession that I was researching (Asselin, 2003). I retained my identity as a physiotherapist as I decided that it would be naïve to not acknowledge the professionalization and biases that I hold because of my physiotherapy background.

I chose to disclose my physiotherapist status to participants not only to assist with recruitment, but also because I thought that concealing my identity might misrepresent both me and the research. I did, however, follow the advice of Colbourne and Sque (2004) and emphasize my researcher role. In the next part of this section I explore the notion that my identity as an insider researcher was the precipitator for some participant misconceptions that manifested as 'ethically important moments' in the research (Guillemin & Gillam, 2004). I outline these misconceptions and describe how reflexivity and awareness of my roles assisted to minimize misconceptions and their potential impact on research methods and ethics. For an extended discussion about the specific misconceptions that occurred and how I used reflexivity to manage them, please refer to Appendix B for my published article titled: 'Reflexivity and the clinician-researcher: managing participant misconceptions'.

Participant misconceptions

I experienced misconceptions on the part of both patient and physiotherapist participants about my role and the purpose of the research. Partly aligning with the well-described therapeutic misconception in quantitative research, where participants confuse research participation with receiving individualized care (Appelbaum, Lidz, & Grisso, 2004; Gail et al., 2006; Miller & Joffe, 2006), such participant misconceptions can have methodological and ethical consequences in qualitative research. Potential patient misconceptions were feeling obliged to participate and expecting treatment or advice as part of the research. In addition, physiotherapist participant misconceptions involved an expectation to receive feedback and a perception of being judged. These misconceptions arose, often unexpectedly, during the recruitment and data collection phases of the research, and engendered careful consideration about my responses.

Patient participants occasionally confused participation in the research with their standard physiotherapy care, and subsequently felt obliged to participate.

This misconception was partly a result of their physiotherapist recruiting them, and partly due to my identity as a physiotherapist as well as a researcher. In addition, patient participants occasionally misconceived my role as being that of a physiotherapist, rather than that of a researcher. During interviews this sometimes manifested as patient participants asking me questions about treatment or requesting further information.

Physiotherapist participants held the misconception that as a physiotherapist observing their interactions with patients I would provide them with feedback on their clinical skills. This expectation is common in qualitative healthcare research undertaken by clinicians, and is suggested to occur because participants who are clinicians perceive researchers to be educators (Asselin, 2003). My research journal provides insight into occasions when physiotherapist participants requested feedback.

Physios do seem to think that I will be giving them 'feedback'. For example, yesterday, Donna (when I thanked her for agreeing to participate) said 'no worries, it'll be good to get some feedback on my practice'.

First ethical 'insider' dilemma:

The practice manager who has agreed to participate would like me to provide feedback to himself and his staff after the observations.

Alarm bells immediately ring in my mind. How do I offer him some professional development without overstepping my research boundaries? How do I keep my professional (physio) opinion separate from the research? I have been working so hard to do this and being asked to provide clinical feedback brought this role/identity challenge to the front of my mind.

After some careful consideration, I explained the difference between my research role and my clinical role. I suggested that I provide a PD

[professional development] session at the end of the research to discuss general findings.

In addition to requesting feedback, some physiotherapist participants, knowing I was a physiotherapist with some experience, appeared nervous and seemed to believe that I was assessing them and their practice during the research observations. In response, I adjusted my demeanour to remain open and relaxed and reminded participants that this was explorative research seeking to understand the interaction.

These misconceptions, and others, were managed throughout the research process through the use of reflexivity. Critical reflection about the biases and impacts that individual researchers have on the research process assists researchers to make these explicit and therefore minimize their influences.

The role of reflexivity

I refer to Wilkinson's (1988) description of reflexivity as 'disciplined self-reflection' (p.493). Reflexivity is often confused with reflection (Finlay, 2002). While reflection is considered to be thinking about something after the event, reflexivity is proposed to be a more immediate, and dynamic self-awareness that involves discipline (Finlay, 2002). In the qualitative research context, reflexivity can assist to express researcher bias and improve methodological and ethical rigour (Cohen & Crabtree, 2008; Kitto, Chesters, & Grbich, 2008; Koch & Harrington, 1998). In my research I actively employed reflexivity for both methodological and ethical reasons.

Methodologically, reflexivity assisted me to understand my biases and their impact on the research processes, and to make these biases explicit. Ethically, I considered reflexivity to be a useful tool to assist me to appropriately manage participant misconceptions that arose as 'ethically important moments' during

participant recruitment and data collection (Guillemin & Gillam, 2004). Reflexive awareness was valuable in minimizing the chance that these misconceptions resulted in coercion to participate or participation with the expectation of receiving treatment advice or professional feedback. For example, understanding my dual role prompted me to emphasize the researcher role to both patient and physiotherapist participants when they requested treatment information and education, respectively. An awareness of these misconceptions also allowed me to adjust my explanations to minimize the chance that future participants would assume the same viewpoints.

Two strategies assisted me in my reflexive journey. Writing in my research diary provided a medium for reflection and self-awareness. Second, professional relationships with fellow sociologists, epidemiologists, medical anthropologists, and others enriched reflexive aspects of this research by extending my viewpoint. I saw my reflexive journey as one of expansion and consideration of different perspectives. Colleagues provided examples from their experiences that helped me to anticipate ethical challenges that might arise. In addition, interested colleagues asked questions about such aspects as where and why patients were seated in the treatment rooms, and possible reasons for the sequence of events. These questions about features of patient-physiotherapist interactions that I had taken for granted, assisted me to adopt an external viewpoint.

Chapter summary

This chapter has outlined the methodological and ethical components of the project. I first explained the conceptual and methodological frameworks that shaped the research. I then detailed the observational and interview methods of data collection that were situated within the interpretive framework and incorporated aspects of both ethnographic and grounded theory methodology. Informed by analytical processes of grounded theory and thematic analysis, I

have explained how findings were generated as elements of interaction that are encompassed by two broad themes. Although the methods are explained as a chronological process in this chapter, I have highlighted the cyclical, iterative, and constant comparative nature of the data collection and analysis used.

Chapters four and five present the research findings derived from data collected in the private practice setting. Each chapter describes one of the two central themes. Each theme captures a style of communication that was integrated into the dynamic process of patient-physiotherapist interactions. Chapter four, titled 'Physiotherapist-led communication' presents detailed descriptions of elements of interaction that support the idea that physiotherapists were directing communication during interactions with patients. Chapter five, titled 'Adapting to build rapport' presents findings as elements of interaction that explain how communication was adapted, and demonstrates that this adaptive communication resulted in increased rapport between patient and physiotherapist. Examples from the respective data sources are used to explain and substantiate elements of interaction presented in each of these chapters.

Chapter four: Physiotherapist-led communication

Introduction

This chapter describes elements of the theme 'physiotherapist-led communication'. These elements were derived from three data sources and are separated into three sections. I first detail elements of physiotherapist-led communication arising from observational data. Second, I present physiotherapist participant interview data to explain my finding that physiotherapists' sense of purpose resulted in them taking the lead when interacting with patients. Finally, I discuss patient confidence in the physiotherapist as an element of the interaction that emerged from patient participant interview data. Patients valued competent physiotherapists who directed communication during their interactions and this engendered confidence. Taken together, these findings constitute the theme 'physiotherapist-led communication' and are depicted in Figure 4.

Figure 4: The elements of interaction from all data sources that established 'physiotherapist-led communication' as a central theme

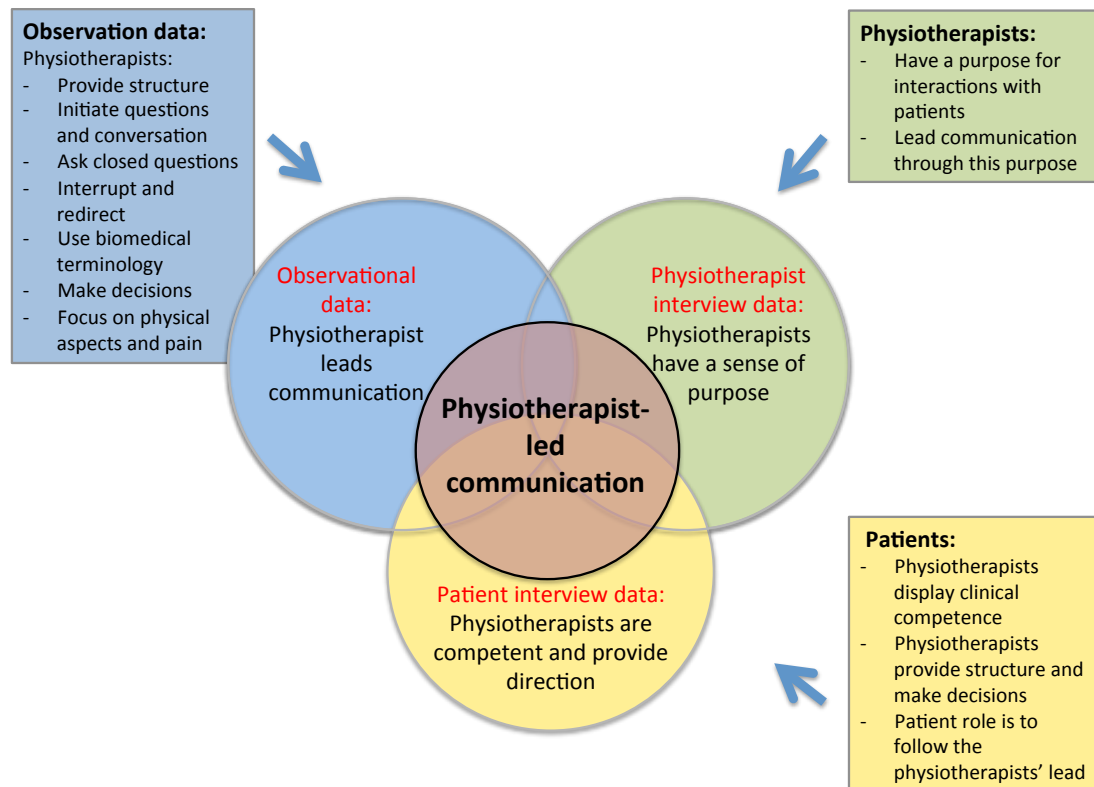


Figure 4 represents physiotherapist-led communication as a central theme of patient-physiotherapist interactions. The three sets of data overlap, demonstrating their commonalities: 'physiotherapist-led communication' is situated in the middle as the central theme. The outside boxes list elements of the patient-physiotherapist interaction that were derived from analysis of each data source. In this chapter I describe each of the listed elements to create a comprehensive picture of the central theme.

Observed elements of physiotherapist-led communication

Data derived from observations of patient-physiotherapist interactions indicated that physiotherapists led communication. In this section I use excerpts of

transcript from observations as well as my field notes to substantiate the key elements of physiotherapist-led communication: a consistent structure, communicative direction, decision making, and content based on physical aspects.

Physiotherapists provided a consistent structure for the interaction

The observed interactions between patients and physiotherapists had a consistent structure. Repeated sequencing or order of events provided a basic framework for many aspects of the structured interactions. The sequential phases were: initial greeting, conversation about the complaint, physical assessment, treatment and education, and finally, closure. Within this structure physiotherapists raised topics as content for communication and generated questions and conversation. They also initiated and led transitions between phases of the structured interaction through gestures, tone of voice, provision of instructions, and use of transitional words. The physiotherapist-led and structured nature of interactions was most clearly demonstrated when physiotherapists directed content and led transitions between phases.

To exemplify this interaction framework I provide some excerpts from an interaction between physiotherapist Donna and patient Jill. In the first example, at the start of their interaction, Donna told Jill her plan and outlined some of the structured framework that all physiotherapists followed when interacting with patients.

Donna: Today I want to do some more balance tests because we haven't finished the whole thing. Generally what I do is, um, I start assessing you and give you something to go away with, some treatment, give you an exercise and then we sort of finish the tests

and I get sort of get more of a rounder fuller picture, otherwise you're here for an hour and a half and it's probably too much. So... can I ask you please to remove your shoes and keep your socks on.

(Physiotherapist Donna, observation 2)

In the next excerpt from the same interaction, Donna justified the framework of 'assessment, treatment and reassessment' as required to successfully 'fix a problem'.

Donna: And I understand that it is frustrating. Um... But, in order to fix a problem, we need to assess the problem and then treat it and then reassess.

Jill: No, I understand all that, it's just, it's just um, stress.

Donna: Yeah, yeah. I understand that. Ok. Just the one last one. I think it'll probably be a little bit easier because you're not turning your head... this time.

(Physiotherapist Donna, observation 2)

In these examples Donna explicitly explained to Jill that there was a structure that she needed to follow for her treatment sessions with her patients. Donna's phrasing and use of 'I' indicated that she intended to lead Jill through her usual structured process. Although not often spoken about as explicitly as in this example, this type of structure was directed by all physiotherapists who participated in the research.

I have incorporated the examples from the interaction between Donna and Jill to demonstrate that physiotherapists were aware that they were providing a structure, but also to highlight other aspects of physiotherapist-led interaction discussed in this chapter. In these passages, and throughout the interaction with Jill, Donna adopted a commanding tone and accentuated many words and

phrases. I remember feeling uncomfortable observing this interaction and noted the physiotherapist's demeanour in my field notes.

Patient sigh, awkward for me.

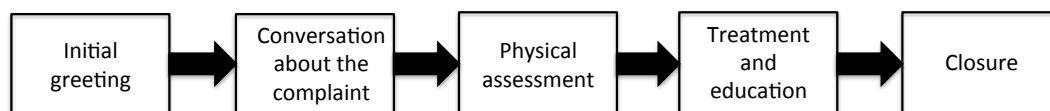
Tone of physiotherapist voice changes – strong ('in charge')

Physiotherapist matter of fact +

(Field notes from physiotherapist Donna, observation 2)

In this interaction physiotherapist Donna led the communication by setting and implementing structure, providing instructions, and being commanding. In the next section I detail the observed phases of the structure as depicted in Figure 5, beginning with the initial greeting phase.

Figure 5: Phases representing structured communication in the patient-physiotherapist interaction



Initial greeting phase

Patient-physiotherapist interactions all commenced with an initial greeting. The greeting often incorporated casual conversation prior to a transitional word that led to a definitive open question from the physiotherapist. The following examples led by physiotherapists Lachlan and James demonstrated this pattern.

Lachlan: I thought you said you lost your bike, Hannah?

Hannah: No, no//...

Lachlan: //Oh that's a bit...

Hannah: The lock, lock on my bike.
Lachlan: Yeah. So, you ah, so you saw Alison? And how's everything been going since then?
Hannah: Really well umm... I've been keeping up with the exercises pretty well. Um, not as religiously as I intended but I've been trying to do them, trying to make myself do them in the morning, when I get up and at night before I go to bed so that at least I do them one of those times.

(Physiotherapist Lachlan, observation 3)

James: What else have you been doing?
Peter: Ah... I've also had my shoulder,
James: Oh, okay yeah, yeah right.
Peter: With the surgeon... there as well.
James: Oh right, okay, I see.
Peter: Um.
James: So... how's everything been going with your back?
Peter: Not bad – back's definitely feeling a bit better. It's coming along slowly, I've started doing some of those core muscle exercises as well from last time which was just... lying on the floor and just tensing.

(Physiotherapist James, observation 3)

In both of these examples, after some initial conversation the word 'so' was used as a mediatory word that marked the end of casual conversation and the commencement of the formal component of the treatment session. In my data, 'alright' was another word often accentuated by physiotherapists to lead the communication through to the next phase of the interaction. In everyday English conversation 'so' is used to preface a shift in interactional agenda or move to the

next phase of interaction (Bolden, 2009). The word 'so', and the open question that followed were therefore markers of a transition in interactional agenda from the initial greeting to conversation about the complaint.

The initial and definitive open question seemed to mark the commencement of the formal component of the interaction. If it was an initial consultation, a question such as: 'what can I do for you today?' (Physiotherapist Tommy, observation 7) was asked. If it was a subsequent consultation, the question was often phrased: 'how are you today?' (Physiotherapist Simone, observation 5) or: 'how has everything been going with your elbow?' (Physiotherapist James, observation 2). Commonly, the physiotherapists gestured to the patient to sit and sat down themselves as they asked this significant question. Opening questions such as these are considered an important component of communicating effectively with patients in both initial and follow-up interactions in healthcare (Silverman, Kurtz, & Draper, 2005).

Conversation about the complaint phase

The second phase of observed patient-physiotherapist interactions featured conversation about the patient's complaint. This phase began when patients replied to the physiotherapist's open question about how they were going or what they wanted to focus upon that day. During this phase of the interaction, talk centred predominantly on pain and the physical body: questions about aspects of pain and the patient's physical function were asked by the physiotherapist and answered by the patient.

An excerpt from a transcript of the interaction between physiotherapist Tommy and patient Marty demonstrates aspects of the conversation about the complaint phase of patient-physiotherapist interactions.

Tommy: Wow, it seems like a couple of places where you have pain.
Marty: To be honest, like the majority of my body is like always sore.
Tommy: Yeah, that has been a factor... okay (*softly*). Now, just tell me um, where is your back pain first?
Marty: The whole back from bottom to top.
Tommy: Um, can you just show me that, tell me, point for me, where is it?
Patient stands up to point out pain.
Marty: Here, here.
Physiotherapist touches (standing behind but looking forward)
Tommy: Yes, here?
Marty: Here.
Tommy: Mhm.
Marty: Like in under...
Tommy: The ribs here? Spreads out here?

(Physiotherapist Tommy, observation 6)

As Tommy and Marty demonstrated in their interaction, physiotherapists followed an agenda of seeking information about the complaint, and asking questions about physical aspects and pain, to which patients answered. Questions were quite specific and often closed-ended. Typical of this phase, the conversation mostly occurred in a seated position but involved moving to standing to specify locations of pain. The conversation about the complaint phase concluded with instructions for the patient that transitioned the interaction toward a physical assessment phase.

Physical assessment phase

As the third phase of the interaction, physical assessment began with physiotherapists providing some instructions and making requests of the

patient. These instructions were the common transition between the second and third phases and frequently incorporated requests regarding the removal of clothing or the adoption of a certain position. In the following example, physiotherapist Sharon transitioned into the physical assessment phase by requesting that her patient Ben take off his shirt and providing some instructions about what the next components of their interaction would involve.

Sharon: Well now, what I want to do is um... if you don't mind we'll get you to maybe take off the shirt. Okay?

Ben: Mhm.

Sharon: And um, I'll have a feel of the muscles, see...

Ben: Right.

Sharon: When I get you to do a few movements, see what's bringing on the pain. Okay?

Ben: Yep.

(Physiotherapist Sharon, observation 6)

As Sharon explained to Ben, the physical assessment phase involved the physiotherapist directing the patient to perform certain movements and to assume particular positions. In concurrence with many transcript examples, Sharon frequently used 'I', demonstrating that she led the physical assessment. Typically, patients assumed a passive role during this phase as the physiotherapist moved them around, commonly using touch to facilitate and feel movements and tissues.

To illustrate the physical assessment phase of the interaction, I provide two further transcript excerpts. In the first example physiotherapist Simone instructed patient Rosalind to perform certain physical tasks such as hopping. In the second example, physiotherapist Kate asked patient Lucy to perform some

movements and then used her hands to feel aspects of Lucy's lower back. Both of these examples show a clear lead from the physiotherapist who provided instructions and directed the agenda through the activities.

Simone: Okay. Can I get you to do a single leg hop? Okay (*10 seconds of hopping noise*). How's that feeling?

Rosalind: That's fine, but what I was doing was jumping on that night.

Simone: Yeah (*5 seconds of hopping again*).

Rosalind: Yeah that's fine.

Simone: Okay. Is that uncomfortable... in the ankle... at all?

Rosalind: No.

Simone: No. Um, can I get you to jump on... (*pause 3 seconds and shuffling*)... on two spots? Let's have a look.

(Physiotherapist Simone, observation 5)

Kate: Just have a seat on the edge of the bed and we'll just have a look at your rotation as well and see if that bothers your higher up point. (*Lucy sits on plinth and Kate twists her body around*) How's that?

Lucy: Mmm.

Kate: Is that, where, where you pulled it?

Lucy: Yeah.

Kate: And that way?

Lucy: That's not as sore.

Kate: Not as bad, yeah. Okay. Just pop down on your back first, I just want to feel that...

Lucy: (*Sighs*)

Kate: How's that up there?

Lucy: Ah... mmmm.

Kate: That's alright... and there?

Lucy: No that's alright.
Kate: That's ok?
Kate: And if I give a bit of pressure to the right higher up? That's alright.
Lucy: It's there... but it's not//
Kate: //But it's not too bad... and then... that's tight, tight through there.
Lucy: Yep.
Kate: Nasty tight.
Lucy: Yeah... ooh.
Kate: Oooh, different to...?
Lucy: Mmm.
Kate: ...Yeah. Feel how that's sort of a... We'll treat your back and SI joint first and just see what that does but we might need to get in there and loosen that up. Yeah. It's tight.

(Physiotherapist Kate, observation 4)

In the final example above, physiotherapist Kate completed the physical assessment phase of her interaction with Lucy with a brief summary of her findings. With the use of palpation⁴, Kate highlighted where Lucy's body was 'nasty tight'. Kate then provided a short explanation about what the treatment would entail. This summary and treatment outline provided a physiotherapist-led transition to the next phase of the interaction that I term 'treatment and education'.

Treatment and education phase

The treatment and education phase of patient-physiotherapist interactions often involved some form of manual therapy and almost always included exercises,

⁴ Palpation is a medical term for using fingers or hands to feel body parts during a healthcare consultation. The practitioner uses touch to examine features of a body part such as tenderness, texture, and size.

education, and advice. I term this phase ‘treatment and education’ because these aspects usually occurred concurrently. For manual treatment, patients were frequently lying on the plinth on their stomach, side, or back while physiotherapists stood. Educational clinical explanations were frequently provided to the patient by the physiotherapists while they performed manual therapy. The following passage from physiotherapist Clint’s interaction with patient Thomas is an example of the physiotherapist providing a plan, explanation, and education. During this discussion Thomas was lying and Clint was standing and performing manual therapy on Thomas’s shoulder. Thomas had just explained some new feelings he was experiencing in his body.

Field notes: patient looks up at ceiling, very relaxed

Clint: I think it is more just a reflection that you have just upped the ante.

Thomas: Yeah.

Clint: In some things that you’re not used to.

Thomas: Yeah.

Clint: Okay. Not that they’ve necessarily been any dramatic things or anything else like that but they’re just new.

Thomas: Yeah that’s right... maybe the swimming and maybe the jumping round... yeah.

Clint: Ok, and that’s something that you haven’t been (doing)... for a while now, is you haven’t been particularly dynamic.

Thomas: That’s... that’s absolutely right.

Clint: And suddenly in the last few weeks you have asked your system to be a little more explosive.

Thomas: Yeah.

Clint: To do more power sorts of things and exactly, you know that twisting, you know, where you are getting that catch and being

caught out a little bit, where you are getting that faster sort of thing.

Thomas: Yep.

Clint: Is, you know, I think probably more consistent with that... that change in demand.

Thomas: Right.

(Physiotherapist Clint, observation 2)

This is a good example of the patient listening and agreeing with information and advice provided by the physiotherapist. As commonly occurred, the physiotherapist led the discussion with minimal patient input.

Following manual therapy, the 'treatment and education' phase of the structured interaction generally concluded with patients practising exercises in conjunction with explanations provided by the physiotherapist. Physiotherapists also imparted instructional verbal communication during the latter stages of the treatment and education phase as demonstrated by physiotherapist Kate and patient Richard in their initial interaction.

Field notes: Patient's hands crossed sitting patiently waiting for Kate while exercise sheet prints out. Physio leans in toward patient (and moves chair closer). Looking closely at patient face as explaining. Patient looks at paper exercise sheet.

Kate: Okay. So – that's the first one we did, standing with our feet together, squeezing the buttocks so you do the small squat.

Richard: Yes (*softly*).

Kate: And then this is on the one leg so.

Richard: Oh right.

- Kate: So just doing exactly the same thing that you are doing there and what you are really concentrating on with this one is keeping your hips level.
- Richard: Yes.
- Kate: So you're really controlling through your hips and your knees, this knee's not wobbling all around.
- Richard: Oh right.
- Kate: Then the last one is just massaging that outside of the leg with a tennis ball or something similar. Ah, just, look these two, you do twice a day, and that once a day is fine.
- Richard: Oh right... yep.
- Kate: So I'll give you that, you can pop that in. Can I get... I'm just going to get Jane [pseudonym for the receptionist] to copy this MRI report just so we've got that on your history and ah... we'll come out and see Jane and see if we can find an appointment for Thursday and ah... we'll go from there. Okay?
- Richard: No worries.

(Physiotherapist Kate, observation 7)

In this example Kate followed the frequent pattern of physiotherapists deciding and implementing a plan for follow-up treatment. Final instructions reflected the physiotherapist's decisions and plan. These instructions concluded the treatment and education phase and led to closure.

Closure phase

Following the treatment and education phase, closure was mostly short and sometimes abrupt. Closure incorporated final comments from the physiotherapist, with the patient usually replying in agreement. As did Kate at

the end of her interaction with Richard in the previous example, physiotherapist James provided his thoughts and instructions for patient Melanie at the conclusion of their interaction.

- James: And yeah, I mean, I think now that it's settled down, the taping, I'm not too concerned about it being, coming off in a day's time.
- Melanie: Yeah, cool. Okay.
- James: It's getting better anyway, so.
- Melanie: Good.
- James: Alright, I'll see you in a week.
- Melanie: Alright.
- James: Thanks.

(Physiotherapist James, observation 7)

The example transcripts demonstrate that closure was also initiated and led by the physiotherapist. Topic transition markers or minimal links such as 'so' and 'alright' were often used by physiotherapists to transition to the closure of interactions, just as they were in the initial greeting phase (Ainsworth-Vaughn, 1992; Bolden, 2009). In the previous and following examples, physiotherapists James and Tommy used the word 'alright' to transition to the closure of their interactions with their patients.

- Tommy: Alright, no worries, um any other questions?
- Jacqui: No, that's fine. That's all done.
- Tommy: That's all done. Good, um... so I'll catch you on the twenty-second.

(Physiotherapist Tommy, observation 5)

Sometimes physiotherapists offered patients an opportunity to ask questions during the closure phase, as in the example above; however, patients rarely

made any queries. Moreover, patients tended to be very agreeable in their responses and never initiated or finalized closure.

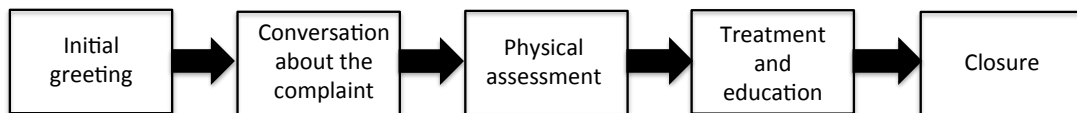
Discussion regarding the structured interaction

In presenting the structure of patient-physiotherapist interactions, I have made two key points: physiotherapy interactions incorporated five consistent phases and physiotherapists led the phases and the transitions between them. The five phases, as depicted in Figure 6, reflect communication phases previously described in medical and healthcare communication literature (Brunett et al., 2001; Frankel & Stein, 1999; Silverman et al., 2005; White, Levinson, & Roter, 1994). As a physiotherapist I also recognized a direct correlation between these phases of communication and stages of the physiotherapy consultation routinely taught as part of physiotherapy education, and outlined in physiotherapy textbooks and instructions for documentation in physiotherapy⁵ (for example, Erickson, McKnight, & Utzman, 2008; Fruth, 2014; Hengeveld, Banks, & Maitland, 2014; Mosby's field guide to physical therapy, 2010; Thompson, 1997). As taught in physiotherapy schools, the phases and structure of the interaction were similar for both initial and follow-up consultations and have therefore not been treated separately in this section. Correlation with some components of physiotherapist clinical reasoning processes, such as diagnostic reasoning, hypothetical-deductive reasoning, and procedure, is also evident in the interactional structure that I describe here (Edwards et al., 2004; Jones et al., 2008).

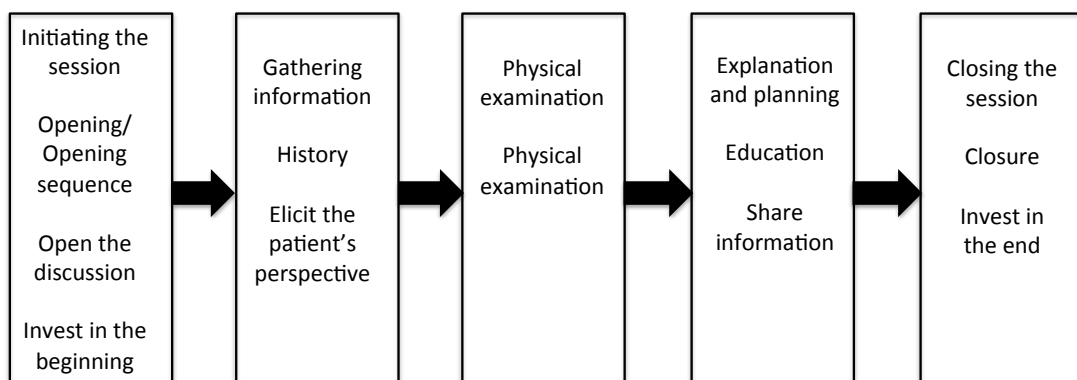
⁵ Appendix F is the assessment form for University of Melbourne Master of Physiotherapy students as a further example of the structure routinely used by physiotherapists.

Figure 6: Comparisons between phases of patient-physiotherapist interaction and phases of patient-practitioner communication

Phases of the structured patient-physiotherapist interaction:



Phases or components of patient-practitioner communication as previously described:



(Brunett et al., 2001; Frankel & Stein, 1999; Silverman et al., 2005; White, Levinson, & Roter, 1994)

Although the five phases observed in patient-physiotherapist interactions aligned closely with those described in the broader healthcare communication literature, there were some differences (see Figure 6). The initial greeting or initiation of the session is widely recognized as the first phase of the patient-practitioner interaction in healthcare and incorporates a greeting and initial opening question (Frankel & Stein, 1999; Gafaranga & Britten, 2003; Silverman et al., 2005). This was evident in my data. The second phase, that I termed ‘conversation about the complaint’, is titled ‘gathering information’ or ‘the history’ in communication skills training (Silverman et al., 2005, p. 17; White et al., 1994). Silverman and colleagues (2005) list two components of this phase: gathering biomedical information and understanding the patient’s perspective and context. As my research examples highlighted, the focus in patient-

physiotherapist interactions was on gathering biomedical information; the patient perspective and context for the biomedical information were less emphasized. I therefore suggest that the patient's perspective was diminished or missing during the 'gathering information' phase of physiotherapy interactions.

The third phase identified in my observational data, 'physical assessment', aligns directly with the 'physical examination' phase as the third phase of communication (Silverman et al., 2005, p. 17; White et al., 1994). There is, however, a notable difference between the findings presented here as 'treatment and education' and the medical description of the fourth phase 'education and planning' or 'sharing information' (Brunett et al., 2001; Silverman et al., 2005, p. 17). This difference is represented in the nomenclature: that is, physiotherapy interactions include an active treatment component.

The active treatment component may be significant as a defining aspect of physiotherapy practice and communication. An active intervention including manual therapy and exercises in conjunction with education is almost always included in private practice physiotherapy interactions (Casserley-Feeney et al., 2008; Harman et al., 2011; Jull & Moore, 2012). Physiotherapy patients expect to be treated in a 'hands on' manner (Potter et al., 2003b) and, as Poulis (2007a; 2007b) highlights, need to be actively involved in the therapy provided. This pattern differs considerably from a medical interaction where patients would probably expect to leave with a script, referral, information, or request for an investigation. Active treatment is therefore a feature specific to physiotherapy and may influence the style and type of communication used, particularly with regard to provision of information and education.

Finally, closure or 'closing the session' (Silverman et al., 2005, p. 17) is an established component of patient-practitioner interactions (Brunett et al., 2001;

White et al., 1994). Features of closure in the observed physiotherapy interactions relate closely to those reported to be part of the medical interaction (White et al., 1994). Specifically, length of closure is usually less than one minute, the practitioner occasionally asks whether the patient has questions, patients rarely ask questions, and the practitioner leads the closure (White et al., 1994). Hence, led by the physiotherapist, closure in physiotherapy interactions has similar features to closure in other healthcare interactions.

Two previous studies of patient-physiotherapist interactions described a similar structure. Delany (2005) outlined a process of structured clinical communication derived from audio-recorded patient-physiotherapist interactions in private practice in Australia; Thornquist (1990) referred to a history taking component followed by a physical examination in initial physiotherapy encounters in Norway. These described structures relate directly to the order in which physiotherapists are trained to undertake tasks during their clinical training and are clearly reflected in the communicative phases of physiotherapists' interactions with patients observed in this research. As specific examples, in physiotherapy clinical practice and education the communicative phase I depicted as 'conversation about the complaint' is termed the subjective assessment, 'physical assessment' is the objective assessment, and 'treatment and education' is treatment (Erickson et al., 2008; Thompson, 1997).

The transitions that occurred within the structured interaction were clearly physiotherapist-led. Words used as transition markers by physiotherapists, such as 'so' and 'alright' have been described to function as a minimal link or the beginning of a sudden topic change in patient-physician interviews (Ainsworth-Vaughn, 1992; Fisher & Groce, 1990). The implications of sudden topic changes are that the preceding discourse is not acknowledged and that power is held by the person who has shifted the topic, in this case, the physiotherapist

(Ainsworth-Vaughn, 1992). In the observed interactions physiotherapists led and controlled the transitions as well as the topics or content of conversation, suggesting that physiotherapists were holding or claiming power and leading the interactions.

In summary, in this section detailing structured interaction in physiotherapist-led communication, I have shown that physiotherapists directed the communication throughout, and noted that this was particularly evident in the transitions between structural phases. Subsequently, I have related the observed structure to stages of interaction taught in physiotherapy clinical training. The structure also correlates closely to the framework of the medical interview, with the exception of the 'conversation about the condition' and 'treatment and education' phases of physiotherapy interactions. These differences indicate some aspects of interaction specific to physiotherapy, most notably the inclusion of an active treatment component.

Physiotherapists provided communicative direction

Within the structured interaction there were elements of communication suggesting that physiotherapists provided communicative direction. I observed and documented how physiotherapists initiated conversation, asked closed-ended questions, and frequently interrupted patients in a manner that was directing or redirecting of the focus of the interaction. Much of the language, phrasing, and style used by the physiotherapist seemed to direct the patient toward the physiotherapist's perspective or agenda. Physiotherapists also used a commanding style and biomedical terminology to drive their agenda. In this section I detail these elements of physiotherapist-led communication using examples from observational data.

Physiotherapists initiated conversation and questioning, and asked closed-ended questions

During the observed interactions, physiotherapists almost exclusively initiated conversation and questions. This pattern was apparent in examples I provided in the structured interaction section. As I re-listened to audio-recorded interactions, I also noted that some patients neither asked a question nor initiated conversation while interacting with their physiotherapist. Questions that physiotherapists asked were frequently closed-ended, particularly during the conversation about the condition and physical assessment phases of communication. Such questions were particularly prevalent in initial consultations. The short transcript that follows is taken from the second consultation between physiotherapist Tommy and patient Michael, and demonstrates a sequence of closed-ended questions asked by Tommy.

- Tommy: Mhm – have you been on any pain-killers as well?
Michael: No, I just took um, took a ‘Nurofen’ yesterday.
Tommy: Did it help you?
Michael: Nah.
Tommy: No? It didn’t help? No?
Michael: No.
Tommy: And did you try other pain-killers like ‘Panadol’, ‘Voltaren’ or anything like that?
Michael: Um, I kept putting ‘Voltaren’ on.
Tommy: Yeah, you mean the ‘Voltaren’ gel? Did that help you?
Michael: Ah no, it didn’t help.

(Physiotherapist Tommy, observation 1)

In conjunction with being closed-ended, at times questions asked by physiotherapists were suggestive or leading. In the previous transcript, patient Michael indicated that the medication ('Nurofen'⁶) he took did not help. Indicating that he felt the medication should have helped, physiotherapist Tommy asked again, 'No? It didn't help? No?' This is a subtle example of the physiotherapist imposing his or her expectations and agenda on the patient through his or her questioning style.

On numerous occasions physiotherapists asked open-ended questions and immediately followed them with clarifying or closed-ended questions. Physiotherapist James asked his patient Simon to explain what aspects of his back pain had improved. Before Simon answered, James provided a number of leading and clarifying questions as shown in the transcript below.

James: You said that it has improved, so what aspects have improved? Has it been the mornings have been better? Or when you get out of a chair?

(Physiotherapist James, observation 1)

Such closed-ended questions direct the patient towards specifics based on the physiotherapist's knowledge and understanding and arguably limit the patient's ability to voice his or her perspective. Closed-ended questions are also termed convergent questions as they limit or restrict the response (Silverman et al., 2005). Patients are controlled or directed by this style of questioning (Roter & Hall, 2004). The predominance of closed-ended and leading questions is, I suggest, a further example of communication that is led and controlled by the physiotherapist.

⁶ 'Nurofen' is a brand name for a type of anti-inflammatory medication available over-the-counter in Australia.

In accord with my results, other physiotherapy research has concluded that physiotherapists use aspects of closed enquiry such as closed-ended questions in their communication with patients (Cruz et al., 2012; Edwards et al., 2004; Haswell & Gilmour, 1997). As an example, Edwards and colleagues (2004) observed expert physiotherapists interacting with patients and commented that the interaction was at times: 'obviously controlled by the physical therapist and characterized by closed questions' (p.324). Contrasting with these findings, Haswell (1997) acknowledged that both open and closed enquiry should be used in patient-physiotherapist interactions, with an emphasis on open enquiry to gain the patient's perspective where possible. Closed enquiry allows the physiotherapist to control aspects of the interaction, including the patient's speech and, as a consequence, patient concerns may be neglected (Cruz et al., 2012; Haswell & Gilmour, 1997).

Physiotherapists interrupted and redirected

Another way that physiotherapists directed the focus of the interaction toward their agenda was by interrupting or redirecting. This usually occurred when patients were explaining their experiences and perspectives. Characteristically, the physiotherapist interrupted in order to return to his or her agenda, whether it was questioning for more detail, or providing an explanation. In most instances the conversation reverted to physical aspects of the patient's experience or condition as a result of the interruption. To illustrate, physiotherapist Simone interrupted her patient Margaret's explanation about the heat to ask her next question. Simone clearly pushed her agenda of wanting to understand about exercises and physical responses and, in doing so, disrupted Margaret's statement about the heat not helping her pain. Simone's use of the word 'right' is definitive and re-directive.

Simone: Mmm, usually the heat does quite well.
Margaret: Yeah... I dunno. It didn't really do much// for me pain wise
(*muffled*).
Simone: //Right. Have you been doing any stretches that we have gone
through the last time?

(Physiotherapist Simone, observation 1)

As a second example demonstrating redirection, physiotherapist Lachlan acknowledged his patient Emily's 'nagging' pain and used the word 'alright' to transition to his next question about what aggravated or eased the pain.

Lachlan: Have you tried um, any sort of, heat, or anything like that?
Emily: Oh I guess, yeah, the heat pack.
Lachlan: Yeah.
Emily: That's it.
Lachlan: Yeah. Okay. It's hard isn't it when it's that sort of, just that nagging.
Emily: Yep.
Lachlan: Pain and... yeah. I can imagine it would be (*softly*). Alright, so...
when you do sort of feel it come on and you go for your break and
you might get out of that...do you sit down or do you stand up for
your break?

(Physiotherapist Lachlan, observation 5)

Many examples of physiotherapists interrupting or redirecting to continue with their agenda occurred in my observational data. Similar physiotherapist interruptions were reported in observational research that explored clinical reasoning practices in musculoskeletal physiotherapy in Portugal (Cruz et al., 2012). Cruz and colleagues (2012) suggested that physiotherapists interrupted patients to assist them to retain control, reduce the subjectivity of the interaction

process, and assist a more streamlined clinical reasoning process. My data suggest that these reasons are also likely to be relevant in an Australian setting.

Interruptions have been described as a strategy that physicians use to claim power in medical interactions (Ainsworth-Vaughn, 1995). Literature from the medical profession describes interrupting as being common practice: 'In typical interviews, physicians either ignore or interrupt patients' storied accounts' (Hyden & Mishler, 1999, p. 178). By dominating the course of the interaction through questioning techniques, physicians maintain power, and control the direction of the interaction (Hyden & Mishler, 1999). The consequences of interrupting, or constantly redirecting the agenda to the practitioner's perspective, need to be considered. Clark & Mishler (1992) suggest that interrupting blocks the ability of the physician to hear the patient's story. From their observational research in Sweden, Josephson & Bülow (2014) concluded that physiotherapists often ignore or reject patient resources that relate to a patient's conditions or personal characteristics. Physiotherapists' communication techniques may therefore be limiting their opportunity to understand patient's stories. In the discussion in Chapter six I deal further with issues and consequences of power.

Physiotherapists had a commanding presence

Physiotherapists were specific, direct, and commanding in their instructions to patients. These types of instructions were most frequent during the treatment and education phase when patients were undertaking movements and exercises. In the following example, patient Chloe was commanded to perform her hip exercises by physiotherapist Donna.

Donna: Pushing, push your leg in. No, no. As in adduct⁷, adduct your hip.
Just pushing like that.

Chloe: Oh.

Donna: Pushing, pushing. Come on. And relax. Push your leg in. And relax.
Pushing. Does that hurt when you do that?

Chloe: I can feel it a bit. Yep.

(Physiotherapist Donna, observation 4)

Both the words chosen and the manner in which they were spoken indicated the importance that physiotherapist Donna placed on the specifics of the movement being performed. The underlined words in the transcript were emphasized by Donna and were stated with some intensity. Donna used these commanding and direct instructions to engage and motivate Chloe to undertake the exercise. It is difficult to compare this element of the patient-physiotherapist interaction with other healthcare interactions because the active movement and exercise components associated with this commanding style are rarely present. The commanding style that physiotherapists adopted is, however, a further element of physiotherapist-led communication.

Physiotherapists used biomedical language

Physiotherapists frequently incorporated biomedical terminology or jargon during interactions with patients. In the previous example, physiotherapist Donna used the term 'adduct' as part of an instruction. During the interaction with Chloe, Donna continued to use biomedical language.

Donna: And we need to get you onto some of that AB/PAB work.

Chloe: Yep.

⁷ Adduction is an anatomical term for the movement of a body part toward the midline or centre of the body.

Donna: Um, so pelvic floor and ab work. Pelvic floor, core, and ab, to get this muscle working.

Chloe: Yep.

Donna: A bit better so you can prevent things like um, diastasis, a split in your diastasis rectii.

(Physiotherapist Donna, observation 4)

After mentioning 'AB/PAB' work, Donna proceeded to provide an explanation of 'pelvic floor, core and ab' but later, 'diastasis, a split in your diastasis rectii' was not explained. Donna did not clarify whether the patient understood what she meant by any of these terms. There is evidence that patients have difficulty understanding biomedical terminology and jargon such as those used by Donna (Cedraschi, Nordin, Nachemson, & Vischer, 1998). It has also been established that patients being treated with lower back pain understand the majority of terms differently from the way that health professionals intended them to be understood (Barker, Reid, & Lowe, 2009). Clarifying understandings and the use of a common language are suggested techniques to ensure that appropriate terminology is used and understood by both parties (Barker et al., 2009).

The use of biomedical language by physiotherapists emphasizes that the interaction is occurring in a healthcare context and that the physiotherapist, as the healthcare provider, is directing the interaction. Using medical and physiotherapy terminology may be viewed positively as a demonstration of physiotherapist knowledge. It may also, however, be viewed negatively and classified as use of jargon, with possible consequences for patient understanding (Cedraschi et al., 1998; Roberts et al., 2013). Whichever view is taken, biomedical terms were used as part of instructional phrases and highlight the physiotherapist's focus on a clinical agenda throughout my observational data.

This section has introduced five further elements of patient-physiotherapist interactions that suggest that these interactions are predominantly physiotherapist-led. Physiotherapists were observed to initiate conversation, ask many closed-ended questions, interrupt or redirect conversation, provide commanding instructions, and incorporate biomedical language in their interactions with patients. Many of these features have been observed or discussed in medical contexts, but have rarely been acknowledged in patient-physiotherapist interactions. As another component of physiotherapist-led communication, I next present observational data and refer to literature that suggests that physiotherapists make decisions in the patient-physiotherapist interaction.

Physiotherapists made decisions

In addition to leading the structure and initiating aspects of communication, physiotherapists led the decision making process during the observed interactions. Observed and audio-recorded decision making processes typically involved physiotherapists stating what they believed should happen, and the patient providing a short agreeable reply. It was common for decisions to be made by the physiotherapist and communicated to the patient as a plan without consulting the patient for an opinion. Four main decisions were communicated during interactions: type and amount of treatment to be undertaken during the session, an appropriate home exercise programme, the goals for the treatment, and when the patient should return for follow-up treatment.

I provide excerpts from transcripts to illustrate the decision making processes occurring in the observed interactions. In these examples, physiotherapists stated their decision about treatment, exercises, goals or follow-up, and the patient usually provided a short agreeable reply. The physiotherapists did not

tend to explicitly ask whether the patient was in agreement with their decision and happy to proceed. Non-verbally, however, physiotherapists indicated that they were seeking patient agreement through the use of eye contact and body language. Patients typically offered short positive verbal replies with associated compliant body language.

Physiotherapist Kate and patient Richard demonstrated this pattern of decision making regarding treatment and activities that Richard should and should not perform at home. In this example, Kate provided background reasoning for her decisions about treatment and activity limitations.

Kate: You've got a little bit of stiffness through this outside muscle more so than the other side. The other thing I've noticed, your kneecap is a little bit tight.

Richard: Yes.

Kate: And that's probably just because of what's happened over the last couple of months, it's just stiffened up a bit because you've been favouring your knee and because you are tight through this outside muscle.

Richard: Yeah (*muttered*).

Kate: So what I'm going to do today, I'm going to get in and loosen up the iliotibial band which is the muscle down here (*pointing*).

Richard: Oh right (*quietly*).

Kate: We're going to stretch your kneecap out a bit and we'll give you some exercises just to give you a bit better control through the knee. I'm more than happy for you to get back on the bike, I think that'll be fine.

Richard: Oh that's good.

Kate: What we just need to avoid is those really deep squats at the moment so if you're, yeah packing anything down low, don't do it by squatting down onto your knees at the moment.

(Physiotherapist Kate, observation 7)

Physiotherapist Sharon and patient Robert demonstrated a similar pattern when deciding what type of treatment would be performed during their interaction.

Sharon: Okay (*softly*). I'm just going to try and get the muscles to relax first.

Robert: Yep.

Sharon: Okay. And then I'll do a bit of stretching for this part where you get the headaches.

Robert: Mhm.

Sharon: Okay, and then we work from there.

Robert: Yep.

Sharon: Okay.

(Physiotherapist Sharon, observation 1)

This pattern of decision making was also utilized when deciding what exercises Robert would practise at home.

Sharon: Okay relax (*softly*) okay so now we've done this about 10 times, okay so I want you to practice the same thing at home 10 times.

Robert: Okay, yep. Both sides?

Sharon: Um both sides//

Robert: //or just the left?

Sharon: No, do both sides.

(Physiotherapist Sharon, observation 1)

Physiotherapists also directed decision making regarding treatment goals during interactions. The physiotherapist usually outlined the goals to the patient whose role was limited to agreeing with the suggestions. In the following transcript, physiotherapist James and his patient Simon demonstrate a common sequence of decision making about goals. In his interaction with Simon, James also made the decisions about when Simon would return for his next treatment session and what he wanted Simon to focus upon in the meantime.

James: So your goals for me mainly are, is to, maybe add another day of walking.

Simon: Yeah.

James: Continue doing the exercises.

Simon: Yeah.

James: Um... and... yeah and we'll touch base in the new year and see how your, your back is feeling then. And I also want you to keep an eye on how the mornings are going.

Simon: Yeah.

(Physiotherapist James, observation 1)

It is notable that many physiotherapists phrased the decisions from their perspective. They used phrases like: 'I think', 'I want you to...' or 'your goals for me are...' These phrases indicate that physiotherapists were presenting their view or decision, and imply that the patient should concur with their decisions. In psychology, self-determination theory describes this type of practitioner-initiated decision making as part of a controlling climate (Ng et al., 2012). Phrases like 'for me' are listed as examples of controlling language that reduce the patient's autonomy and competence (Lonsdale et al., 2012). Controlling phrasing is another indicator that decisions were made and led by the physiotherapists.

In research exploring decision making processes in physiotherapy, authors have proposed that shared decision making is appropriate practice in the physiotherapy setting, but concluded that physiotherapists mostly undertake decision making on behalf of their patients (Cruz et al., 2012; Dierckx et al., 2013; Jones et al., 2014; Stenner, Swinkels, Mitchell, & Palmer, 2016). Goal setting, a form of decision making, has also been demonstrated to rarely include active patient participation in physiotherapy interactions in the United Kingdom (Parry, 2004), and a therapist-led goal setting process has been described in a Swiss context (Schoeb, 2009). Limited patient involvement in making decisions is not specific to physiotherapy: a recent systematic review covering all health practitioner-patient interactions also concluded that patients were rarely incorporated into the decision making process (Couët et al., 2015). These research results reflect my findings.

Shared decision making involves decision making where both parties are involved, share information, and achieve consensus about treatment to be implemented (Bainbridge & Harris, 2006; Charles, Gafni, & Whelan, 1997). In the goal setting segments of interactions, I observed that patients did not tend to share information, and that the patient role in achieving consensus was often to agree with the physiotherapist's suggestions. Barriers to incorporating the patient in a shared decision making process have been listed as: time restrictions, a strong physiotherapist-driven desire to treat, and lack of physiotherapist awareness that patients preferred to provide an opinion and share decisions (Dierckx et al., 2013; Jones et al., 2014; Parry, 2004). These barriers may provide reasons for the pattern of physiotherapists making decisions in patient-physiotherapist interactions.

Focus on physical aspects and pain

The content of the observed interactions was dominated by talk about pain and physical aspects, and represented another element of physiotherapist-led communication. As I highlighted in the earlier section on structured interaction, discussion about the type and location of patients' pain was particularly prevalent. Talk also centred around physical activity limitations and the presence of other physical symptoms such as weakness or pins and needles. The focus on pain and physical or biological aspects was present throughout the interactions, but was particularly prevalent during the conversation about the condition, physical assessment, and treatment and education phases of the interaction.

Physiotherapists generated the interest in pain and physical symptoms during the interactions by frequently asking questions and referring to these topics in their explanations to patients. Physiotherapists' questioning regarding pain was often specific and repetitive. They focussed their interest on location, nature, and quantification of pain, as well as factors that impacted upon the pain experienced. My transcripts demonstrated the attention given to pain and physical symptoms throughout the interactions, as evident in the five following examples.

The first example provides evidence of a focus on location of pain during the conversation about the condition phase of an initial interaction between physiotherapist Lachlan and patient Emily. Lachlan asked many questions about the location of pain on Emily's body. The discussion coincided with pointing and touching to confirm the specific region of pain.

Lachlan: We'll have a good look at the neck then. Alright... so whereabouts is your pain exactly?

Emily: Here... like in the back... there.

Field notes: Patient (Emily) points to areas of pain on her body

Lachlan: Sorry, just point exactly. Yep. Just down there? Yep. And does it go down into your arms at all?

Emily: No.

(Physiotherapist Lachlan, observation 5)

A specific focus on the location of pain continued in the physical assessment phase of interactions between patients and physiotherapists. Palpatory or 'hands on' aspects of assessment and treatment concentrated on the physical source or location of pain.

In a second transcript, physiotherapist Sharon stood palpating Robert's back as he lay on his stomach on the plinth. As my field notes state, Sharon's palpation and associated conversation were directed toward finding the location and the anatomical structure causing the pain. During this exchange, everything else about the patient, except for his body and his answers to her questions about pain, were seemingly irrelevant.

Field notes: Touching/palpating different areas and asking for verbal responses to feel.

Sharon: Pain here when I touch?

Robert: Not much, no.

Sharon: Not much? What about here?

Robert: Nup.

Sharon: Okay, what about here?

Robert: No.

Sharon: Here?
Robert: Nup.
Sharon: Here?
Robert: Nup.
Sharon: Anything//...
Robert: // Yep, yep.
Sharon: Yeah. Okay.
Robert: Yeah here a little bit.
Sharon: Is that pain now?
Robert: A little bit, not much.
Sharon: But if I touch here there is pain?
Robert: Yep (*slightly pained*).
Sharon: Okay, it's the muscle.
Robert: Mmm.
Sharon: Okay, what about here?
Robert: Nah, that's not much.

(Physiotherapist Sharon, observation 1)

Many such examples of repetitive and persistent questioning about pain by physiotherapists occurred in the observed interactions.

A third transcript example from the physical assessment phase of an interaction between physiotherapist Tommy and patient Marissa is indicative of the attention given to different aspects of the experience of pain. These aspects included the causes, severity, location, and impact of specific movements or positions on pain. In this example, Marissa sat and Tommy stood facing her, making eye contact and using his hands to assist Marissa to perform the movements.

Field notes: overpressure on retraction +/- rotation⁸ (Tommy was adding pressure to a neck movement)

Tommy: Just let me, let me... now change it again (*5 seconds silence*). How does that feel?

Marissa: Yeah that hurts.

Tommy: Whereabouts?

Marissa: Through there.

Tommy: Does it bring it on more... or less... when I do that?

Marissa: Well it's hurting and it wasn't hurting there before.

Tommy: Okay, that's enough. Stop. How much pain is it when I did that?

Marissa: Not bad.

Tommy: 0 to 10?

Marissa: It hurts now though, yeah.

Tommy: It hurts a bit. Yeah. Stand up for me... Raise your arm up. Okay maybe, maybe just stand forwards. Any pain when you are doing that? Do you, do you have a singlet underneath?

Marissa: Yep.

Tommy: Do you mind taking this top off so we can have a look at your shoulder underneath? Thank you. Okay, any pain there while you are lifting?

Marissa: Yeah, a little bit.

Tommy: Whereabouts?

Marissa: Where your hands are.

Tommy: Both sides?

Marissa: Yeah.

Tommy: And relax down. Okay. I'm just going to put my hand underneath your shoulder just to stabilize and help you with your...

Marissa: Yep.

⁸ This description is referring to a physiotherapy assessment technique for a neck movement.

Tommy: Hang on, relax. Relax for me. Relax. Okay yeah, that's it. And now lift your hand up again. Tell me whether that still hurts or not.

Marissa: Yeah, it hurts under here.

(Physiotherapist Tommy, observation 7)

Tommy continued with his focus upon the presence and severity of patient Marissa's pain. As a fourth example, Tommy persisted in seeking a rating for Marissa's pain experience even though Marissa stated 'I don't normally rate things'. The physiotherapist's need to rate and quantify pain was frequently observed during interactions and exemplifies a physiotherapist-driven agenda.

Tommy: Okay, and from a scale of 0-10 how much would you rate the pain in here?

Marissa: At the moment it's okay, it's mainly up here is a bit painful.

Tommy: What about up here? How much would you rate it?

Marissa: Um.

Tommy: 0 being nothing....

Marissa: I don't normally rate things.

Tommy: No, so is it//mild or ...

Marissa: At the moment it's probably like 3 but um, if I do a lot of lifting then it gets really painful and I have to sit down.

Tommy: Sure.

Marissa: And it takes like a few hours for the pain to go away.

(Physiotherapist Tommy, observation 7)

A final example about pain as a topic of conversation during patient-physiotherapist interactions demonstrates physiotherapist interest in factors that impact upon pain. In this example, during the conversation about the condition phase, physiotherapist James asked questions of patient Melanie about

factors that might affect her pain such as specific activities like getting out of a chair or time of day.

James: Yeah. Yep. Right. So no resting pain? No pain getting out of chairs?
No morning soreness?

Melanie: No.

James: Nup. Okay. Well that's good.

(Physiotherapist James, observation 6)

In addition to the focus on pain, physiotherapists frequently enquired about other physical symptoms. Particularly during the conversation about the condition phase, physiotherapists seemed to be seeking insight into both the causes of, and relationships between, physical symptoms. As an example of this interest in physical symptoms, physiotherapist Tommy provided an explanation, and then questioned his patient Dan.

Tommy: (chuckles) Yeah, you need to use your muscles more. So that is why I'll have a look at to see whether it's your pain limiting your muscle function today or whether we can do some strengthening exercises for your neck muscles.

Dan: Sure.

Tommy: Okay and you know the last time I mentioned about you, um, checking whether you have any of those symptoms like um double vision, dizziness, saliva in your mouth, um difficulty speaking, difficulty swallowing... any of those symptoms come on?

Dan: I didn't have any of those.

(Physiotherapist Tommy, observation 2)

Finally, during the 'treatment and education' phase of interactions, physiotherapists continued to ask about pain and physical symptoms. Education

was usually presented in a scientific, anatomical manner incorporating physical or biological content. Physiotherapists often referred to wall charts, diagrams, or models to explain parts of the body and influences on movement and pain. In the following example, during the treatment and education phase, physiotherapist Clint refers to a human body muscle chart on the wall as he is describing fascial tissue⁹ and normal movement to his patient Sally.

Sally: I think my walk is making my knees hurt a tiny bit.

Clint: They're just having to work a bit harder.

Sally: Yeah.

Clint: Because if you're not getting your momentum system going... normally when you walk, okay, you have this lovely sling system here, it's alright you don't need to... but there's this lovely sort of fascial sort of sling.

Field notes: leans over patient on bed to point to muscle charts.

Sally: Yep.

Clint: That runs along... okay, that basically can run like a bit of an elastic band so as you start to step through it stretches out one, recoils, makes it easier. If you are walking like a tin soldier...

Sally: *(soft laughter)*.

Clint: Every step is harder work for you.

(Physiotherapist Clint, observation 3)

Discussion regarding pain and other physical symptoms was frequent during both initial and follow-up interactions. The examples illustrate that the content of conversation focussed on physical aspects of a patient's presentation, particularly with regard to pain. They also demonstrate that physiotherapists

⁹ Fascial tissue is a sinewy band or sheet of connective tissue within the body that supports and separates muscles.

initiated these topics of conversation and therefore led the interaction with respect to content as well as providing structure and making decisions.

A focus on pain and physical aspects in physiotherapy is unsurprising given that physiotherapy is a healthcare profession concerned with movement and functional ability (WCPT, 2011). The plethora of assessment and treatment techniques used by physiotherapists to address patients' pain is clear evidence of this. Observational studies of aspects of musculoskeletal physiotherapy practice provide examples of a similar discourse occurring between patients and physiotherapists (Cruz et al., 2012; Roberts et al., 2013). Moreover, research exploring interactions in physiotherapy has suggested that physiotherapists perceive and treat the patient as a physical body, and dichotomize body and mind (Cruz et al., 2012; Thornquist, 1994). These findings correspond with a predominant focus on physical aspects and pain as observed during interactions in this research.

In this section I have outlined physiotherapist-led elements of patient-physiotherapist interactions arising from observational data, providing transcripts and field notes as evidence. To progress my suggestion that physiotherapists led interactions, I next present purposeful communication as an element derived from analysis of the physiotherapist participant interview data. The notion that physiotherapists are purpose driven implies that physiotherapists lead and direct communication to achieve their agenda in interactions with patients. The results in the following section demonstrate this and align with the central theme of physiotherapist-led communication.

Physiotherapists had a sense of purpose

A dominant element emerging from physiotherapist interview data was that physiotherapists each had a specific agenda and purpose when interacting with their patients. In response to interview questions, physiotherapists described what they valued and their perception of what they focussed on in their interactions with patients: they each had a sense of purpose. During interviews, they kept returning to their purpose, consciously stating these intents as the core part of their interactions with their patients.

Physiotherapists spoke passionately about their stated purpose and as the interviewer I sensed that they were each motivated by their own individual aim when interacting with patients. Some physiotherapists described a scientific and clinical purpose that was concerned with their therapeutic agenda; some indicated an empathic purpose that demonstrated a concern for their patient's experience of physiotherapy; others expressed an intent that encompassed both of these aspects. I have situated these intentions along a spectrum between scientific, clinical, and empathic, caring purposes as demonstrated in Figure 7.

Figure 7: Spectrum representing the range of communicative purposes described by physiotherapists

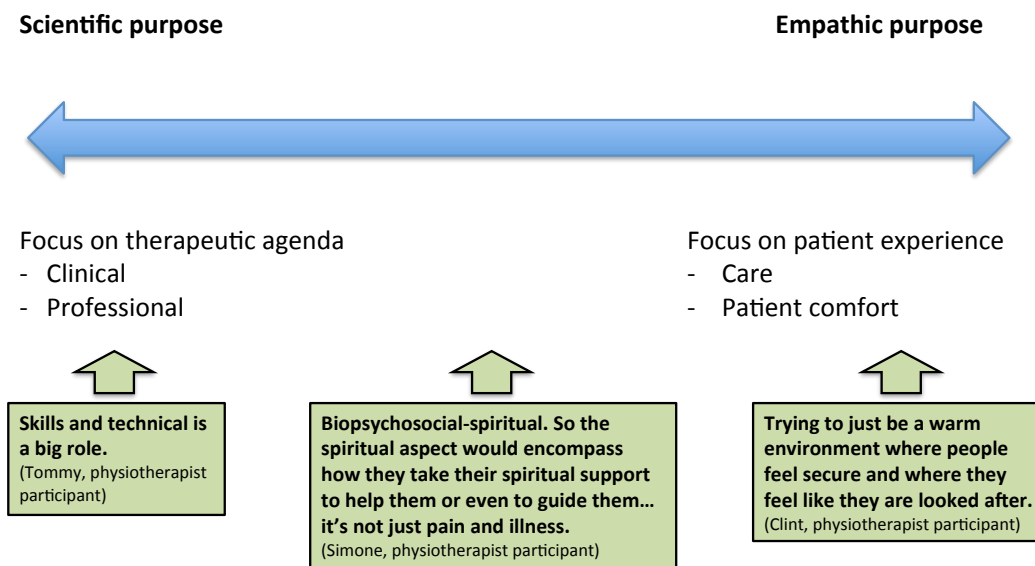


Figure 7 provides a spectrum representing the range of purposes that physiotherapists described as their aims when interacting with patients. Each purpose is associated with different therapist foci and each is reflected in different styles of communication. Below some points on the spectrum are example quotations from physiotherapist interviews.

I next detail examples of physiotherapists describing a professional, clinical, therapeutic purpose.

Physiotherapist James explained his clinical approach and the characteristic of clinical physiotherapy that was important to him: control over the physiotherapy treatment regime when interacting with patients.

The relationship I like to be with people is that I am the person they come to see if they've got a problem, I give them exercises, they do them for me

and then I can give them more things to do when they get better at doing the ones I've given them, and I make that pretty clear.

(James, physiotherapist participant)

Physiotherapist Tommy talked about a focus on specific clinical components such as clinical skills and clinical reasoning.

Skills and technical is a big role and how you reason it plays a big role.

(Tommy, physiotherapist participant)

In a similar way, physiotherapist Donna reflected the goals of physiotherapy clinical practice when she stated her purpose as being rehabilitation. Donna's aim was to rehabilitate patients to achieve a positive long-term outcome. Education was described as a significant component of this.

Rehabilitation is my aim, it's not about a quick fix and so what I try to explain to my clients is that ok... this may take four weeks, six weeks, it may take six months but it is better than fixing you quickly and you keep coming back again. So education is a big part of what I do because I believe it empowers the client to, not only um, attend... but also to continue with their rehab so that they can achieve a better outcome.

(Donna, physiotherapist participant)

In contrast to these clinical purposes, other physiotherapists described their purpose as being empathetic, making patients comfortable, and creating a safe environment. Some physiotherapists also aimed to demonstrate care and to help patients to feel comfortable. All of these aims represented a central concern for the patient's experience of physiotherapy.

Caroline spoke repeatedly about focussing on empathy and having an empathetic approach:

I think my model is to ah, be empathetic, um, but to be friendly and engaging and um, yeah and I think also to, I mean I think they're the main things, to be friendly, engaging, open and empathy . . . I think empathy is a really big one; to meet them at their story is really important.

(Caroline, physiotherapist participant)

Two further transcripts from physiotherapist interviews show that, as part of their purpose, physiotherapists expressed concern about how patients felt. Physiotherapist Lachlan repeated many times that his purpose was to make patients feel comfortable. Lachlan considered this a central objective for physiotherapists interacting with patients, and described how interactions with patients become difficult and unsuccessful if patients are not comfortable. Similarly, physiotherapist Clint spoke about patients needing to feel as though they are being looked after, explaining that his purpose was to create a safe environment for each patient.

You need to let them feel comfortable about themselves.

(Lachlan, physiotherapist participant)

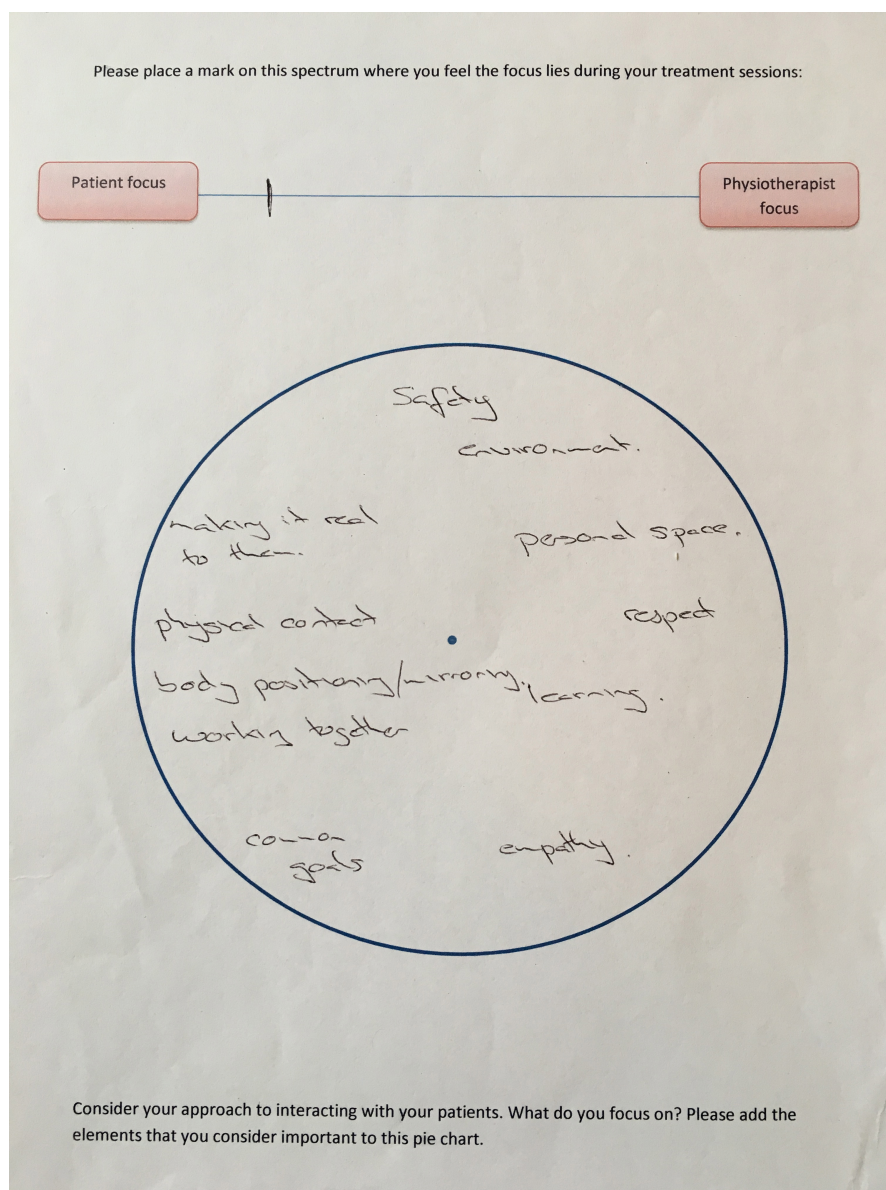
Being in a safe enough environment that they feel that they can try new things and be confident that they'll be ok... It's trying to just be a warm environment where people feel secure and where they feel like they are looked after.

(Clint, physiotherapist participant)

A sense of purpose was also portrayed in written, graphic elicitation data obtained during interviews with the physiotherapists. Physiotherapists were

asked to write what they focussed upon when interacting with their patients, by providing a visual representation on a circle (see Figure 8 and Appendix C). The words physiotherapists wrote reflected the purposes they described verbally in interviews. For example, Clint wrote words that represented a concern for the patient experience as part of his purpose to create a safe environment (see Figure 8).

Figure 8: Graphic elicitation data for physiotherapist participant Clint



Examples of words written as part of the graphic elicitation data that reflected a scientific purpose were: physical content, assessment, physical skill set, outcome measures, manual therapy, pain, disability, treatment, knowledge, clinical thinking, exercise, planning, and patient education. In contrast, many other words reflected an empathic purpose, such as: respect, ethics, safety, working together, rapport building, empathy, patient's preferences and beliefs, likability, realism, understanding, common sense, and pleasant. Some physiotherapist's written data included mostly clinical words, others incorporated more words that related to a consideration for the patient's experience. Graphic elicitation data therefore reflected each physiotherapist's individual purpose.

These communicative purposes were not mutually exclusive, and each existed somewhere along the spectrum presented in Figure 7. For example, physiotherapists who described a clinical focus for their communicative practice often mentioned a concern for the experience of their patients but emphasized achieving clinical, therapeutic goals as their central purpose. This example would be situated closer to the left of the spectrum. As I will explain in Chapter five, even though physiotherapists each had a core sense of purpose, they also described and demonstrated an ability to adapt and adjust their focus based on their clinical judgement of what was required to achieve the best physiotherapeutic outcome.

Physiotherapists did not consciously employ established approaches when interacting with patients

During interviews I asked physiotherapists whether they used models, styles, approaches, or theories to inform or guide their communicative practice. Their replies indicated that they were not aware of models or approaches for communication.

I wouldn't know models as you're asking me. No, not specifically like that.

(Sharon, physiotherapist participant)

I don't really know the models, so... yeah.

(Caroline, physiotherapist participant)

I can't think of the people or the theories... I don't think I've read a lot about it, I think it's more so um, me as a person.

(James, physiotherapist participant)

When prompted, however, physiotherapists were very aware of the ideals of biopsychosocial and patient-centred approaches. They had heard of these concepts, and were able to describe the relevant ideals of each. As an example, physiotherapist Tommy explained patient-centred care.

In my impression what patient-centred care is, it's all about the patient ah, in that you would do things according to patient needs, patient wants and stuff like this.

(Tommy, physiotherapist participant)

Interestingly, many physiotherapists had not considered that these theories related to them. When asked about patient-centred care, physiotherapist Kate stated:

Ah yes, I guess I think of that as a hospital based thing, I don't know why, and I've probably never really thought about what it means. I've heard it around there in the media or whatever but I haven't ever really considered that it related to me.

(Kate, physiotherapist participant)

Equally, when prompted, physiotherapist Donna knew about the biopsychosocial approach but had not considered how she would implement it during her interactions with patients.

Ooh, yes, yes, yes...Yeah, but I'm just wondering how you would change your communication style to the client? Would you be talking about the psycho... the psychological, social and the biological impact of their, their problem, is that what you are saying?

(Donna, physiotherapist participant)

Physiotherapists did not consciously relate their described purposes to established theories or approaches. Rather, they proposed their own objectives that demonstrated that their communication was purposeful.

Each physiotherapist had a personal approach or philosophy for interacting with patients. The evidence from my data suggests that physiotherapists in the private practice sector do not have a unifying philosophy of practice consciously employed for interacting with patients. This finding has implications for both the profession and for physiotherapy education. Evidently, different contexts and patient characteristics may impact upon the manner in which physiotherapists choose to interact, but an overarching framework can support and guide how physiotherapists interact with patients. Whether a common theory or approach is needed for physiotherapists to draw upon when interacting with patients requires consideration. I discuss this further in Chapter seven.

I suggest that having a sense of purpose and specific foci for interacting with patients accounted for the observed interactions incorporating physiotherapist-led communication. Physiotherapists led communication with each patient to achieve their desired purpose. In particular, the descriptions of a clinical, scientific purpose seeking to rehabilitate, aligned closely with physiotherapist-

led elements of communication described in the first section of this chapter. Communicative features reflecting this clinical purpose included: physical aspects as content; physiotherapists making decisions about treatment, exercises, and follow up; and physiotherapists being authoritative.

The various senses of purpose that physiotherapist participants described could also be interpreted as learned routines. A sense of purpose or routine has many possible drivers. Notably, in the private practice setting, time limitations and the need for physiotherapists to see patients promptly in order to receive sufficient remuneration are likely to have a considerable influence (Hudon et al., 2015). In addition, physiotherapist's personal and ethical values, in combination with the process of professional socialization (Ajjawi & Higgs, 2008), are likely to have influenced the individual's specific sense of purpose.

The final section of this chapter incorporates patient participant interview data and, as a consequence, details elements of the interaction from the patient perspective. In this section I explain how patients valued competence and direction arising from physiotherapists demonstrating a sense of purpose.

Patients had confidence in physiotherapists who were competent and provided direction

In their interviews, patient participants indicated that they had confidence in physiotherapists who demonstrated clinical competence and provided effective direction. To further strengthen the central theme of the chapter, in this final section I present these patient perspectives as elements of physiotherapist-led communication. I first outline how patients believed that physiotherapists demonstrated clinical competence by incorporating clinical explanations and using technical touch. Second, I explain how patients expected communication to

be led by physiotherapists and appreciated the physiotherapist providing structure, making decisions, and leading communication during their interactions. Finally, I present patients' perceptions that their role was to provide information and take direction from the physiotherapist during their interactions.

Patients valued demonstrations of clinical competence

In their interviews, patients described ways in which physiotherapists demonstrated clinical competence. Providing clinical explanations, using technical terms, referring to clinical posters and models, and using technical touch were aspects that patients valued. Each patient described competencies directly related to the incorporation of biomedical content into the interaction; this linked with the focus on physical aspects and pain that I observed during the research. The physiotherapist agenda to incorporate biomedical content was therefore appreciated by patients.

Clinical explanations incorporating biomedical terms demonstrated clinical competence

Receiving explanations in a biomedical, clinical manner was important to patients. Use of biomedical terms and anatomical charts as well as explanations of treatment, anatomy, or pathology provided in a manner that displayed clinical knowledge were all perceived by patients to increase their confidence in the physiotherapist. Patients Jocelyn and Laura explained that their physiotherapists' demonstrations of clinical knowledge engendered confidence that their physiotherapists 'knew what they were talking about'.

They were both nice, nice quiet people um, who obviously knew what they were talking about, mmm. Yeah, mmm and I mean you put your faith in people because you expect that yes, they know what they are doing.

(Jocelyn, patient participant)

So whenever she's done any kind of manipulation she's always explained what she's doing and why and as I said before, sometimes she uses the different terms for the muscles or bones or whatever and sometimes I don't completely understand what she's talking about but I think her way, just gives me confidence in her because she knows what she's talking about.

(Laura, patient participant)

Laura elaborated on the use of technical, clinical, biomedical terminology.

For me, I just kind of like that she's using technical terms because it, I don't know, maybe that makes me feel more confident in what she's doing, like she's showing that she knows what she's talking about, she's not just doing random things.

(Laura, patient participant)

The final statement 'she's not just doing random things' implies that patients value structure based upon clinical knowledge as the antithesis to 'doing random things'.

Patients reported appreciating the use of anatomical models and posters as part of physiotherapists' clinical explanations during their interactions. Two examples from patient interviews substantiate this point.

She really pinpointed ah ok, you seem to have a bulging disc in this way. And she really created a pretty clear picture in my mind, because I've had back injuries before I know what the vertebrae basically looks like, um, but she pulled out a model as well and said 'here' and yours is protruding that way so when you've done this... describing how I did it, that's what's caused the little bit of a push out there.

(Peter, patient participant)

I think she's good like, you know, she's got all these posters and stuff on the wall of, you know, the skeletal system and the muscles and yeah, and she always kind of points things out on the pictures about which, which part of the body is wrong and which muscles that exercises are working on and those kind of things and she's got... I think she must give um lectures or something at, you know, physio conventions, if such things exist because she's had a lot of presentations that she's opened up for me and she's kind of gone through a few things. So... in that regard she's definitely provided more education I guess than other physios... and I do appreciate that.

(Laura, patient participant)

It was evident from patient interviews that patients' perceptions of physiotherapists' competence were determined through demonstrations of clinical competency and biomedical knowledge.

Technical, clinical touch demonstrated clinical competence

Patients also valued technical touch used in conjunction with verbal clinical explanations.

Definitely in terms of things being described but also being shown, you know, if, being told and touched, I think that helps, pinpoint and explain things better, um, I mean, James always explains an exercise by doing it.

(Peter, patient participant)

The use of technical, clinical or therapeutic touch by physiotherapists further instilled confidence in patients. This touch, that I term 'technical' touch, incorporates palpation, movement facilitation, manipulation, mobilization¹⁰, massage, and other types of manual therapy as used by physiotherapists as part of assessment and treatment (Hengeveld et al., 2014). Technical touch was considered by patients to be a vital component of the interaction. Even though occasionally painful, patients were willing to be touched as part of the physical assessment and treatment and education phases of the interaction. Patients reported that physiotherapists conveyed knowledge and an understanding of the body through their hands in a way that demonstrated their competence as therapists.

In her interview, patient Melanie described that she felt secure in the hands of a competent physiotherapist who used technical touch to move her body in a mechanical way.

Melanie: It doesn't feel like when you go for a therapeutic massage because the way they move your body, it's like it's a machine.

Amy: Right, okay.

Melanie: And they're testing it and moving it and that kind of thing so I don't, you know, it certainly doesn't feel soothing or anything.

Amy: Yeah, okay.

Melanie: It feels like you're being moved into place and I guess manipulated.

¹⁰ Manipulation and mobilization are manual therapy techniques performed at various velocities to increase movement or reduce pain in a joint.

Amy: That's a really interesting point. Okay. So, you feel like it's sort of more, not mechanical but could you use another word to describe it? When you sort of say you are being moved.

Melanie: I think mechanical is good. Yeah. Yep, yeah. I guess, hmm... so I guess it's about the proper functioning of the body and so they're, they're I feel like they are looking at your body as a machine, I suppose.

Amy: And how does that make you feel?

Melanie: Hmm...Good. Yeah. Like I'm in competent...

Amy: Hands?

Melanie: Hands yeah. And I do like it when they kind of show you on the chart where the muscles are that they are targeting and why they are doing what they are doing.

(Melanie, patient participant)

Technical touch was a medium through which physiotherapists demonstrated to patients that they understood their bodies. Clinical explanations were able to communicate knowledge, but arguably more powerful was the knowledge that physiotherapists conveyed through their hands. As observed, physiotherapists frequently used their sense of feel through technical touch to locate the source of the patient's symptoms, and this was an effective means of instilling confidence in the patient. Patients stated that physiotherapists 'knew their body' and valued this as an important part of their interactions.

Because she just seemed to. She'd just touch my knee and I'd go 'ouch' you know. She just knew the spot where to go.

(Jocelyn, patient participant)

She feels... I think she's got a very great knack to know where the muscles are that are kneaded and tight and she sometimes knows better than I do. She'll go is it sore there? I'll go YEAH!... I didn't know that was sore there, so... I think she's very in tune with how the body works... and how it's the areas that are... more likely to be susceptible to pain, yeah.

(Margaret, patient participant)

With John, I explain where all the pains were and he just virtually went straight to where the spot was.... He said 'that's where it's coming from, that's where it's causing the pain in such an area'. That's why I've sort of liked him better because he sort of knew about my body more than what I did.

(Robert, patient participant)

Sometimes with the physio you can think, well they know what they're doing, I'll... that really hurts but I'll just let them keep going because they're the expert so...and I'm pretty used to that too so I expect to be poked and prodded and I think that's really important to them understanding where the issue is, so... and it's nice to feel like, 'this is where your issue is, right there' you know, and instantly you go 'right, well that's where it's been hurting me.'

(Peter, patient participant)

In the final example, patient Peter highlighted the expertise and scientific knowledge that physiotherapists conveyed and obtained through technical touch. Even if this technical touch was painful, Peter and other patient participants emphasized the importance of having their complaint located and were willing to tolerate this pain because it assisted their recognition of the physiotherapist as an expert. Peter further explained:

I think so too when people have made the choice to go and see a physio, they really just want to be fixed, so, and often people are in pain, you know I've been so badly in pain with my back I felt I'd cut off my finger now just to have that gone – I just want it gone, so, you'd do anything. You know, this guy says I'm going to have to do this, it's going to help you, alright go for it, do it. Do it. I'm happy, I'm happy that this is going to be a step to improvement.

(Peter, patient participant)

Despite sometimes being painful, technical touch as treatment was also reported to increase patient confidence by reducing patients' symptoms. Patients spoke of the effectiveness of technical touch in the form of massage and manual therapy, emphasizing the importance of this as a highly regarded part of the physiotherapy interaction. I provide four examples.

Kate was good at that. She'd say well, this is probably going to hurt a bit, but after you'd get up and go 'oh, that feels so much better' you know. So, she'd be working into it, into the glut or something that was linked to my back and you'd get up and just be 'ah, that works a treat' so, so yeah, the touch is massively important, I don't think you could do it without it. Not effectively anyway.

(Peter, patient participant)

Like I said the massages work wonders and I was seeing him twice a week and once a week and even now, there's a massive difference when I walk out of there. Definitely.

(Jacqui, patient participant)

A hand or touch, I think it does play a lot of the healing part of things I think.

(Margaret, patient participant)

But with John it just, he pushes the muscles and it's like a rolling on the dough (*making hand movements like kneading*). That sort of thing and it really sort of wrinkled out all the – all the stress and the pain.

(Robert, patient participant)

When asked about the best part of their interactions with physiotherapists, patients consistently spoke about manual treatments that utilized technical touch.

Well, the manipulations in terms of making me feel good.

(Laura, patient participant)

The massages. Go in there. Go in there. Honestly go in there! The massages are awesome... hands of magic!

(Jacqui, patient participant)

These quotations confirm that technical touch was a notable component of patients' interactions with physiotherapists. Patients reported that physiotherapists' touch conveyed an understanding of their body, gave them symptom relief, and made them feel that they were being treated in a competent manner. These components assisted to increase reported patient confidence in the physiotherapist.

Authors have previously considered that physiotherapists' touch can convey an unspoken understanding of patients' bodies (Bjorbaekmo & Mengshoel, 2016; Rutberg, et al., 2013). Touch is acknowledged as a defining and frequently present characteristic of patient-physiotherapist interactions and has been described as a communicative medium for perceiving and conveying information

(Bjorbaekmo & Mengshoel, 2016; Nicholls & Holmes, 2012; Roberts & Bucksey, 2007; Roger et al., 2002). The following is an example of physiotherapists' touch conveying 'knowledge and security'.

The persons with migraine sensed that the physical therapist knew what he or she was doing, as recognized in his or her touch. A skilled physical therapist's touch felt professional and mediated a feeling of knowledge and security. "... it's quite amazing too, he [my physical therapist] feels . . . just by feeling, that there is the right spot [acupuncture spot] . . . I have complete trust in him; I could almost be unconscious and still be there, I totally trust him" (Rutberg et al. 2013 p. 1617).

Other studies have expressed similar ideas. For example, Bjorbaekmo and Mengshoel's (2016) findings suggest that physiotherapists listen and understand patients through embodied practices, particularly touch. It seems that patients perceive physiotherapists' ability to develop and convey an understanding through touch.

The link between the demonstration of expertise and medical knowledge by a practitioner and the attainment of patient confidence has been identified in the medical setting (Beiting, Dale, Meltzer, & Arora, 2014). Similarly, in a musculoskeletal physiotherapy setting in New Zealand, patients spoke about feeling confident when physiotherapists explained what they were doing and 'knew what they were talking about' (Kidd et al., 2011, p. 158). My data corroborate with these findings and provide further insight into the patient perspective of physiotherapist competence and expertise.

Recognizing that patients develop confidence through demonstrations of clinical knowledge and technical touch, I suggest that biomedical clinical content is necessary in physiotherapy interactions. With regard to biomedical clinical

content, patient interview data correlated closely with physiotherapist interview and observational data. The physiotherapists reported a focus on clinical components including pain and biomedical knowledge, and I observed a distinct focus on physical aspects and pain during patient-physiotherapist interactions. The patient perspective suggests that this focus on physical aspects and pain was necessary for them to ascertain the physiotherapist's competence.

Patients valued physiotherapists providing direction

Patients expected to be led by the physiotherapist during their interactions. In the second part of this section I present patient interview data that describe patient confidence in a physiotherapist who demonstrated competence by leading the communication. Patients believed that physiotherapists providing direction was an element that made their interactions professional. They expected physiotherapists to determine structure and to make decisions. Finally, patients described their own role as being willing to be directed by the physiotherapist and his or her agenda.

For example, patient Robyn explained that her physiotherapist Clint set expectations and frequently asked questions during their interactions, particularly regarding treatment and exercises; she considered this appropriate. Robyn compared this organized and planned approach to previous experiences of physiotherapy when she had trouble ascertaining the origin of the physiotherapist's ideas. It was clear that Robyn appreciated the structure and expectations that Clint provided.

If we're going to compare communication, he sets, he sets expectations that you should do and they're realistic. And he asks a lot of questions.

The other ones just had these rampant ideas and I'd think 'what, where's this come from?'

(Robyn, patient participant)

Physiotherapists made decisions

Decision making was a clear example of physiotherapists providing direction during interactions with patients. During patient interviews I enquired about how decisions were made. Patients responded that they were content for physiotherapists to make decisions on their behalf. Patients acknowledged their lack of expertise with regard to the body and exercise, and respected physiotherapists as knowledgeable, professional experts. Below I present three examples that demonstrate patients' willingness and expectation that physiotherapists would lead the decision making processes. First, patient Simon spoke about his physiotherapist telling him what to do, acknowledging his own lack of familiarity with exercises.

Amy (interviewer): And what about decisions that are made about what exercises you're going to do and what treatment you are going to have. Can you tell me about that?

Simon: ... he just tells me, shows me the exercises there in the room first and tells me how many times to do it and all that and that's basically it. So... there's not much discussion. Yeah, and then I ask him, how many times a day and all that and then he tells me five times each, everyday... and he told me about general movements and he tells me about that every time and I don't tend to do enough. I think that's good enough because I'm not familiar with exercises and what's good and what's not.

(Simon, patient participant)

Secondly, patient Jacqui expected physiotherapist Tommy to provide direction in the sessions and make decisions about what exercises she should perform at home.

Jacqui: It's up to Tommy. Yep, the way we go and what happens in the sessions and obviously what exercises he wants me to do, that's for him to decide... And I guess he might look at me each session and go: 'alright what's the next movement? What are we going to try and get her to do next?' That's all completely up to him.

(Jacqui, patient participant)

Thirdly, patient Melanie agreed that physiotherapists made most decisions, especially those related to treatment and exercises. She explained, however, that there were some decisions that she preferred to be involved in and provided the example of follow-up treatment sessions.

Melanie: I think they pretty much make the decisions.

Amy (interviewer): Mmm.

Melanie: Yeah.

Amy: And is that... okay for you? Is that what you would expect?

Melanie: Um... oh look, in terms of exercises, if they want to tape me up or that kind of stuff I'm pretty happy with. Um... I guess at a certain point they wanted me to come twice a week and I just kinda had to say 'no, I can't do that' um... but, yeah, I mean, they're going to be looking at the kind of ideal level and then it's what can fit in and what people can pay for... so I think at certain points I have kind of had to say, 'no, I can really only come once' yeah. But everything else, I'm just happy to do what they say.

Amy: Okay.

Melanie: Yeah.

Amy: Yep, and that's what you would have expected?

Melanie: Yeah. I don't think I expected it to be kind of me giving my opinion, I mean they're, I guess, sounds a bit old school to say it but I think of them as the experts and you know I never did biology at school or any of that so I really don't know much, so I do sort of feel like I'm in their hands in terms of decisions.

(Melanie, patient participant)

Thus, patients in this research predominantly believed that physiotherapists should make decisions in their interactions and wanted this to occur. There were, however, some choices, such as the frequency of consultation, that patients perceived were choices that they wanted to make themselves or in collaboration with the physiotherapist. In Chapter six I elaborate on patient choice and explain its role in the relational power dynamic within the patient-physiotherapist interaction.

Allowing the healthcare provider to make decisions, as patients generally did in this research, is contradictory to the ideals of shared decision making that are described and promoted in the literature (Bainbridge & Harris, 2006; Charles et al., 1997; Elwyn, Edwards, & Kinnersley, 1999). In the medical setting, there is evidence that many patients prefer physicians to make decisions on their behalf (Chawla & Arora, 2013; Deber, Kraetschmer, & Irvine, 1996; Degner & Sloan, 1992). My research in the physiotherapy setting establishes that patients consider physiotherapists to be experts and therefore generally expect and want physiotherapists to make decisions on their behalf.

Patients perceived that their role in the interaction was to provide information and be led by the physiotherapist

Mirroring the patient expectation that physiotherapists would provide direction, patients perceived that their role in the interaction was to explain the problem, respond to physiotherapist questions, and allow themselves to be led by the physiotherapist. Patients spoke about answering questions with clarity to provide the information that the physiotherapist required. Two final transcript excerpts from patients Peter and Simon clearly outline the patient perspective of their role.

I try and really create the clearest picture as possible about how it's occurred. I know it's important to diagnosing what's occurred – so yeah, I guess that'd be my role and being able to communicate as clearly and quickly as I can and just respond to the questions I guess and allow myself to be led along the path of whatever questions the physio is trying to use to unearth what the issue is.

(Peter, patient participant)

Well my role is to tell him about what the issues are, the physical issues or the problem and how it's been since the last time I saw him, explain to him about my problems and then I expect him to tell me, what's been... I expect him to tell me what it is and how it's going to affect the back, that's it. Yep.

(Simon, patient participant)

These interview findings suggest that patients approached their interactions as lay people who were consulting physiotherapists as professionals for expert advice and treatment. Patients expected and derived confidence from

physiotherapists demonstrating their competence through clinical knowledge and by leading the communication in their interactions. The patient interview data concurred with the observational data: both revealed that physiotherapists initiated questions, made decisions, and focussed upon physical content while leading communication in their interactions with patients.

The importance of patient confidence in the physiotherapist has been addressed in the physiotherapy literature. Gyllensten and colleagues (1999) reported 'establishing contact and confidence' (p.98) as a component of the interaction between physiotherapists and patients. Interviews with patients have also highlighted confidence as a key requirement for patient-centred physiotherapy in a musculoskeletal setting in New Zealand (Kidd et al., 2011), and as an important part of the experience of physiotherapy for migraine sufferers (Rutberg et al., 2013). Patients therefore appreciate physiotherapist competence and having confidence in the physiotherapist as important components of their interactions.

Patients perceived that their role was to provide clear information and follow the physiotherapist's lead. Correlating with this, patients were observed to follow directions and answer questions as requested by the physiotherapists during observed interactions. As other research in the physiotherapy setting has established (Cruz et al., 2012; Talvitie & Reunanen, 2002), it was rare for patients to initiate questions or conversation. The observed physiotherapist-led style of structured interactions with physiotherapists leading questions, making decisions, and focussing on pain and physical aspects perhaps restricted or limited patients' opportunities to ask questions or initiate conversation. Nevertheless, communication was reciprocal and patients contributed to the interaction by answering questions and explaining their experiences.

Chapter summary

In this chapter I have presented the theme 'physiotherapist-led communication' as central to patient-physiotherapist interactions. Data from three perspectives all substantiated physiotherapist-led communication. The observational perspective provided clear examples and descriptions of many elements of physiotherapist-led communication. Physiotherapists were observed to: lead a consistent structure, direct communication by initiating and interrupting, use biomedical language, make decisions, and focus on pain and physical aspects. Physiotherapist interview data highlighted that physiotherapists were purposeful in their interactions, resulting in physiotherapists taking the communicative lead. Finally, patient interview data revealed that patients valued and gained confidence from the competence and direction that physiotherapists provided when leading communication. These elements of physiotherapist-led communication that emerged from three corroborating data sources are summarized in Figure 4 in the introduction to this chapter.

The data and results presented in this chapter increase evidence that physiotherapists initiate and control communication when interacting with patients in private physiotherapy practice. As I have discussed throughout, many elements of physiotherapist-led communication have previously been described in research undertaken in different settings, validating my findings. Although I have concentrated on providing detailed descriptions of communicative elements, broader interactional concepts have also been included. In particular, the pattern of interaction depicted in my descriptions of physiotherapist-led interaction suggests that the physiotherapists possessed power. Albeit endorsed by patient participants, such power during interactions has implications. I discuss power further in Chapter six.

The suggestion of physiotherapist-led communication is not novel. In fact, it is expected that in a healthcare professional interaction, the practitioner would take the lead and initiate many elements of communication. The present results, however, include data from direct observations to specifically detail communicative elements and provide a comprehensive picture of physiotherapist-led communication. Moreover, the inclusion of patient and physiotherapist perspectives provided an additional layer of understanding. A notable strength of these findings is that three separate perspectives, represented by three data sources, all demonstrated elements of physiotherapist-led communication.

In the following results chapter I present the second central theme of patient-physiotherapist interactions: 'adapting to build rapport'. This theme was also derived from my analysis of all three data sources and is presented as elements of the interaction that arose from each data set. Adaptations that occurred as part of patient-physiotherapist communication are depicted as complementary additives that permeate the structured, physiotherapist-led communication described in this chapter.

Chapter five: Adapting to build rapport

Introduction

Adapting to build rapport was the second central theme of patient-physiotherapist interactions derived from my analysis. This theme incorporates elements of communication that appeared to be tailored to build a connection and to enhance the relationship between patient and physiotherapist. Physiotherapists initiated the majority of adaptations but patients were occasionally also observed to incorporate adaptations, particularly humour, into their interactions. These communicative adaptations were integrated throughout the physiotherapist-led communication that I presented in Chapter four. That is, patient-physiotherapist interactions were physiotherapist-led with adaptations occurring within and around the structured and clinically focussed elements of the interaction.

The adaptations were responsive to the dynamics of an interaction and could also be termed adjustments, alterations, revisions, modifications, or variations. However, Oxford Dictionaries (2016) define 'adapt' as to 'make (something) suitable for a new use or purpose'. I therefore chose the word 'adapt' to explain the modifications observed in patient-physiotherapist interactions because it encompasses a responsive change that occurs for a purpose. In this chapter I demonstrate that the purpose of the adaptations was to build rapport.

Rapport is defined as a 'harmonious relationship' (Spink, 1987). A harmonious relationship in healthcare involves a connection between patient and practitioner that is based upon trust, mutual respect, and understanding (Cole & McLean, 2003). I chose 'rapport' to explain the intended purpose and outcome of adaptations because it provides a picture of the resultant type of relationship occurring between patient and physiotherapist. Throughout this chapter I

provide examples of how adaptive communication was intentionally employed to create the harmonious relationship often evident between patient and physiotherapist. That is, adaptive communication had an instrumental purpose in the patient-physiotherapist interaction. Adaptive, rapport-building communication has not previously been detailed and encapsulated through empirical observational research in physiotherapy.

This second results chapter incorporating adaptive communicative elements is divided into four sections. The first three sections present empirical findings with each section including results from one data source as depicted in Figure 9. The fourth section presents findings from the final stage of analysis that compared my empirical research findings with approaches to healthcare interaction (detailed in Chapter two).

Figure 9: The elements of interaction from all data sources that established 'adapting to build rapport' as a central theme

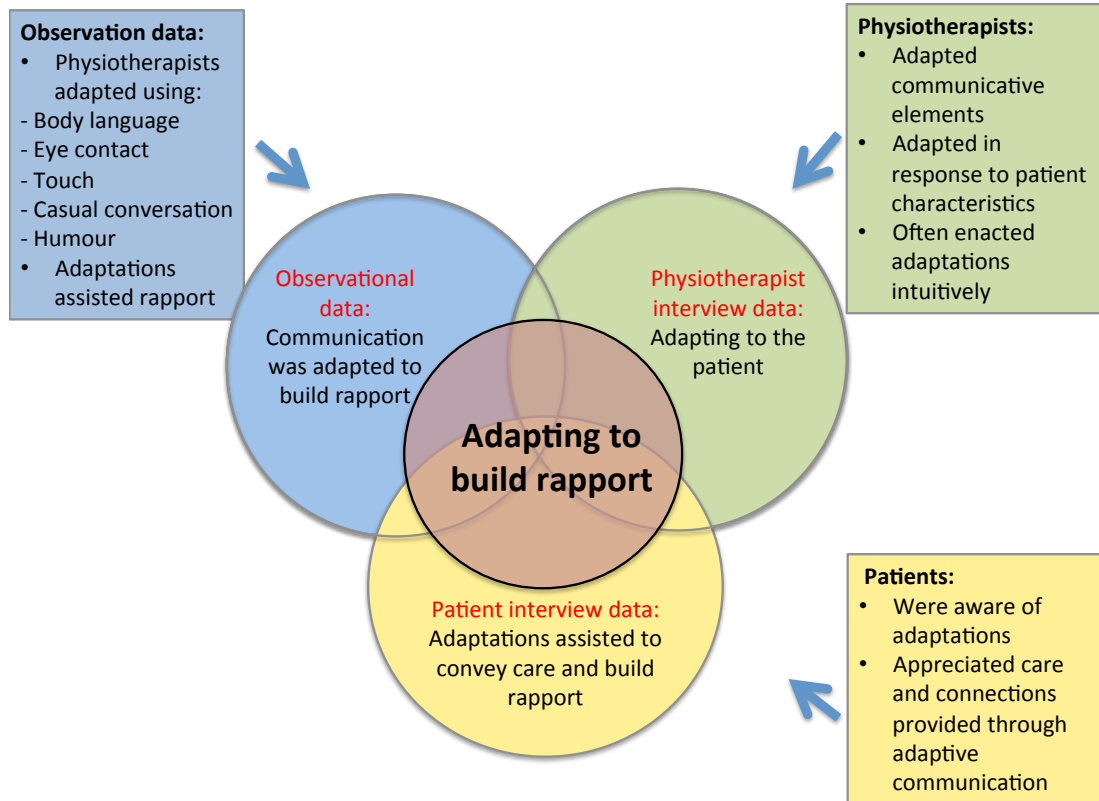


Figure 9 represents the first three sections of this chapter. The central theme 'adapting to build rapport' in the middle of the figure was present in the results from each of the three data sources. This alignment and overlapping of data, represented by intersecting circles, neatly generated the overarching theme of 'adapting to build rapport' as central to patient-physiotherapist interactions. The elements of interactions that emerged from analysis of each data source are listed in the coloured boxes to further substantiate the findings. Throughout this chapter I argue that adapting communication to achieve a harmonious relationship was a central component of patient-physiotherapist interactions in private physiotherapy practice that complemented the physiotherapist-led communication described in Chapter four.

I commence this chapter by presenting my findings derived from physiotherapist participant interviews that highlight physiotherapists' awareness of how and why they adapted communicative elements during their interactions with patients. Second, I use observational data to illustrate elements of adaptive communication and the resultant connections that I observed occurring between patient and physiotherapist. Third, patient participant interview data explaining patients' appreciation for receiving genuine care and having a connection with their physiotherapist is provided. I emphasize that patients believed that these features resulted from the responsive way that physiotherapists communicated with them. Finally, I contrast my empirical findings with features of approaches to healthcare interaction, and establish that generally accepted theoretical approaches to healthcare interaction do not adequately represent the features of interactions occurring between patient and physiotherapist found in my research.

Adapting to the patient: the physiotherapist perspective

I don't communicate the same way with all patients.

(Sharon, physiotherapist participant)

Physiotherapists acknowledged that they adjusted their communication for different patients. In their interviews, they used many phrases and terms to suggest that they altered aspects of communication. These included such adjectives as 'flexible' and 'changing', the verbs 'adapt', 'tailor', and 'vary', and such phrases as 'do things differently', 'change my role', 'get to their level', and 'depends on the individual'. In this section and chapter I collectively term all such communicative changes 'adaptations' and demonstrate that the essential purpose of these communicative adaptations was to build rapport with the patient.

During interviews I asked physiotherapists broad questions regarding their aims and communicative style for interactions with patients. Adapting or making adjustments was regarded as a fundamental part of their communicative practice. They outlined specific communicative elements that they incorporated and changed such as: active listening, non-verbal communication, touch, casual conversation, and humour. Physiotherapists explained that the purpose of these communicative strategies was to make patients feel comfortable and to create a connection between themselves and their patients. My analysis indicated that physiotherapists adjusted their communication during each interaction in response to individual patient characteristics. Although physiotherapists had insight about adjusting their communication, their perception was that adjustments were often intuitive.

The following section discusses three components of physiotherapist perspectives that emerged from physiotherapist participant interviews: communicative elements adapted by physiotherapists, adapting in response to individual patient characteristics, and the intuitive implementation of adaptations. These three components inform the title of this section: adapting to the patient.

Communicative elements adapted by physiotherapists

Physiotherapists described aspects of communication that changed during their interactions with patients. I term these aspects 'adaptive communicative elements'. They included: actively listening, using techniques such as clarifying and summarizing; non-verbal communication, involving responsive body language and eye contact; touch, incorporating adjustments to clinical touch and the addition of caring touch; casual conversation, covering social content; and humour. To explain why they adapted their communication, physiotherapists

spoke of such generic priorities as assisting patient comfort, understanding patients, and making personal connections with patients. All of these priorities are incorporated into my definition of rapport as a harmonious relationship.

Drawing on my interview data, in this section I provide examples of physiotherapists elaborating how and why they responded and adjusted to individual scenarios. These examples are presented under headings for each adaptive communicative element: active listening, non-verbal communication, touch, casual conversation, and humour.

Active listening

Physiotherapists reported the value of active listening both for themselves and their patients: that is, how they listened and relayed what they heard back to the patient using techniques such as clarifying and summarizing. Physiotherapists believed that acknowledging patients' words and meanings allowed patients to feel heard, valued, and understood as equal partners in interactions, subsequently fostering a connection between patient and physiotherapist. Although active listening was largely perceived by physiotherapists to be incorporated as an adaptation toward a focus on the patient experience, physiotherapists also spoke of adaptive communication as having an instrumental value. That is, it allowed patients to provide more information that assisted physiotherapists to achieve their therapeutic agenda. Together, these functions combined to establish 'active listening' as an integral element of the central theme 'adapting to build rapport'.

Physiotherapist Donna explained that she incorporated active listening into her interactions with patients to achieve two-way communication and to gain information about the patient problem.

And also to have a listening ear and to really be mindful that people will volunteer to say things and it might be right out of context but they do it for a reason and, and probably just trying to read between the lines I guess. So sometimes people will say things and it sort of prompts me to ask them a little bit further about what they said to clarify – to obtain clarity. I think another thing would be not only active listening, but also summarizing what I feel to be their main problem. I think that that would be very effective in the sense of when they are talking to me about their problem and saying how it's impacting their lifestyle, it'd be good for me to relay that back and say is it true that this concerns you because of X, Y and Z. I personally think that that works well because it means that they are being listened to, it's not only a one-way communication.

(Donna, physiotherapist participant)

Donna adapted her listening to improve the patient experience and to learn about the problem as a means of progressing her therapeutic plan.

Physiotherapist Simone also highlighted the value of actively listening in order to allow patients to relax and feel comfortable enough to speak about aspects of their lives.

This is something I have learned about patients as well. If you listen to them, they can talk about anything, you know, about their religion, about life about everything. If you sit there and if you treat them and listen to them they will actually want to talk or even want to open up to you even more.

(Simone, physiotherapist participant)

Conversely, physiotherapist James highlighted that typing on the computer, which he saw as a barrier to active listening, reduced his ability to interact appropriately with his patients.

I used to just sit there and type and just... get everything down but I think sometimes it's just, it's too um, it doesn't – it discourages a bit of flexibility with the interview. Whereas if you face the person you can sort of, they sort of understand that you are actually listening to them rather than just again, just being sort of like the all-knowing professional and you can't, you can't interact with them that well.

(James, physiotherapist participant)

A common idea in these explanations about why and how the physiotherapists incorporated active listening was to encourage a partnership, rapport, and more equal relationship. This was described by James as a contrast to the scenario in which the physiotherapist was dominant and the patient submissive.

Non-verbal communication

In addition to active listening, physiotherapists believed that many aspects of non-verbal communication impacted upon the patient experience. They reported explicitly employing body positioning, eye contact, and touch to improve the comfort of the interaction and treatment experience for patients.

Positioning themselves in relation to the patient was important and consciously considered by a number of the physiotherapists. Physiotherapist James reported a deliberate intent to position himself at the same level as his patient.

I suppose body language, mmm, where, when they're talking I generally try to face them and stay at the same level... generally I don't love looking down on people.

(James, physiotherapist participant)

Detailing this idea further, physiotherapist Clint spoke about using his body to mirror the positions of his patients. He explained that he improved the connection with, and involvement of, the patient in the interaction by mimicking the patient's position.

It goes more than the verbal, it goes into the body positions and all that sort of stuff, from a mirroring perspective, I will sometimes choose my body positions as to how I am sitting based on trying to get some different connections, have them involved and um, so, you know, sometimes my legs will start to cross just after theirs or I will start to mimic things a little bit, just to make it a little bit more, more real.

(Clint, physiotherapist participant)

For Clint, 'more real' may have meant that the interaction would be perceived as more human, and that it demonstrated genuine care to the patient.

Making eye contact was another way that physiotherapists perceived that they could improve the patient's comfort.

One key thing I suppose the eye contact is quite important for me and being able to let them feel very comfortable, so it might be um, just trying to get to their level.

(Lachlan, physiotherapist participant)

Here physiotherapist Lachlan describes eye contact and reiterates James's comment about the significance of being at the patient's level. I interpreted Lachlan's description to include both physical and psychological aspects. In addition to physiotherapists placing themselves at a similar physical level, finding a psychological connection with each patient that demonstrated care, compassion, and concern was likely to increase patient comfort while interacting with their physiotherapist.

Adapting non-verbal communication, including body positioning and eye contact, was therefore outlined by physiotherapists as a method of achieving rapport with patients. Touch was a further element of non-verbal communication that was modified by physiotherapists. Even though it is recognized as a form of non-verbal communication, I have given touch a separate heading because it was a particularly significant finding.

Touch

Physiotherapists believed touch to be a powerful communicative tool purposefully employed in their interactions with patients. Touch was perceived to convey care, empathy, and security and, at the same time, to assist in reducing barriers and in forming a connection between patient and physiotherapist. Physiotherapists spoke openly about intentionally changing and adding touch to create a safe space, and to convey reassurance and support in their interactions.

Physiotherapist Clint detailed the powerful effects of touch to create a safe, secure space for patients. He explained how he utilized touch together with body positioning to make patients feel comfortable.

I think it has an enormous power with regards to security, confidence, with regards to empathy, um, and it goes further than just touch it goes

into personal space as well and your ability to measure, to measure that, is really important in the first few minutes. As to how comfortable is this person, what distance do I need to.... So it just creates that extra security, gets them attending to whatever and you can start to chip away at the things that you want to. And I guess I consciously do touch people a lot. It's automatic but there's always reasoning going on behind. I'm consciously knowing that I need to attend in and out.

(Clint, physiotherapist participant)

Physiotherapist Caroline also emphasized the importance of positive and safe experiences of touch for patients.

Probably to a lot of them [patients] is having touch that is safe and feels good and is really important as well.

(Caroline, physiotherapist participant)

Two different types of touch were discussed in physiotherapist interviews: technical touch and caring touch. I characterize touch used as part of assessment and treatment as 'technical touch', and additional touch used to convey care and empathy as 'caring touch'. Physiotherapists Lachlan and Simone considered that the manner in which technical touch was used as part of assessment and treatment was communicative. Simone spoke about using technical touch in a confident and reassuring way that was sensitive to the patient's needs.

It depends on how you touch them as well because um, yeah, if you go in and if they are sore here you give them the sense of touch that they are being looked after, they feel comfortable, they feel soothed and relieved, in a sense and with that they are more comfortable to see you.... I find touch is very important and you have to make them feel comfortable.

(Simone, physiotherapist participant)

As another example, Lachlan said that he used technical touch to reinforce his instructions and information, and to provide patients with a sense of security.

I've noticed that that's actually quite common that I do that to sort of reinforce a point. It's not like a pushing down but just a sort of 'touch'. Particularly, you know, people who are very fearful of their back and those sort of things that, yeah 'things are safe'.

(Lachlan, physiotherapist participant)

In contrast, physiotherapist Donna included caring touch in her interactions with patients. Donna described holding someone's hand as an example of touch conveying support and promoting a connection between patient and physiotherapist.

For some people it's more reassurance in terms of more, holding her hand and saying 'look we're in this together... I'm here to support you and to be, you know, to be available for you to ask me anything or to help relieve you'.

(Donna, physiotherapist participant)

Physiotherapist Clint described how using touch assisted him to make connections with patients by breaking down barriers, and subsequently allowed him to achieve other aspects of his therapeutic agenda.

I think with this lot, touch is really important. We've got to break down barriers. There can't be barriers with regards to touch. It's a real skill, it's a real opportunity that we have that a lot of other professions don't have. Um, and, touch may or may not be the important part of that treatment but it might create the opportunity for the important part to happen. So, for me to be able to talk education wise or for me to be able to hear

someone's, where they are going with particular exercises, or talk to them about progression of exercises or something like that.

(Clint, physiotherapist participant)

Clint highlighted that touch was a valuable medium that physiotherapists can employ to help make patients feel comfortable, and indicated that when patients felt comfortable, they engaged in education and discussion about exercises and treatment progress.

Casual conversation and humour

Physiotherapists described talking socially and laughing as a means of building a connection with patients. I term this talk 'casual conversation'. The content of casual conversation was generally not related to the reason that the patient sought treatment. Physiotherapists explained that casual conversation about personal activities, family, or work helped them to establish common interests and to build a personal connection between themselves and their patients. They remarked that casual conversation and humour were enjoyable and promoted patient relaxation. However, they also noted that it was necessary to achieve a balance between socializing with patients and remaining professional. The following examples from interview transcripts demonstrate that physiotherapists were aware of casual conversation and humour occurring in their interactions, and that they used these communicative techniques to assist them to build an appropriate relationship with their patients.

Physiotherapist James explained his experience of casual conversation in physiotherapy.

I think as a physio, you just find yourself in a conversation about something you just... never would ever talk about but... I think you're

trying to find something that you think that the person might like to talk about, you know, whether it be your crazy cat ladies... and you're talking about cats... I don't know. Finding, I suppose, you want to talk a bit about their problem, but you want to find... something they're interested in so you can talk about that during the session as well. Um, so I try and do that, I try and, I try and remember at least one... someone once told me to document in your notes something interesting, or something the person is interested in, like you know, they could be going away on the weekend so when they visit next time you can ask 'how was the weekend?' but I tend to be able to remember those things, I can't remember a lot of other things but I remember those sort of things. So yeah, I generally always ask them what they're doing with their day or what they are doing for the weekend.

(James, physiotherapist participant)

Interacting with patients in a conversational way was perceived to be an intrinsic component of communication occurring in physiotherapy. Physiotherapist Caroline spoke about connecting with patients on a more human level through casual conversation and humour.

I like a professional relationship but I actually like to have a bit of humanity and humour in it sometimes too, just some realism. I actually do like to connect with them on some non-physio level, so I will often talk to them about their families or their work or... and I'll tell them some stuff about mine as well so I do like to have a slightly more personal connection, obviously within some boundaries, whatever they might be.

(Caroline, physiotherapist participant)

Laughing together brought enjoyment to interactions as emphasized by physiotherapist Lachlan.

I enjoy the job anyway – you come across some pretty funny people. There's just sometimes when I'm laughing, not at them, but we're laughing together. It's good. I think it plays a very important role. When I say very important, I mean, it's a nice aspect isn't it? When people can laugh. But it varies, it depends on every person, you know. It really depends on the individual. Mostly they're making the jokes and those sort of things anyway. You need to enjoy it as well though!

(Lachlan, physiotherapist participant)

Lachlan drew attention to the positive influence of laughter during patient-physiotherapist interactions, including an increase in patient comfort. He also noted the reciprocal benefit of humour in extending the enjoyment to physiotherapists themselves.

The incorporation of casual conversation and humour was important in defining the type of relationships that occurred between physiotherapists and patients. However, while physiotherapists enjoyed chatting and were happy to share some aspects of their lives, they also acknowledged a need for professional boundaries. Casual conversation was described as reciprocal and sharing, but within the professional boundaries that each physiotherapist deemed appropriate. Lachlan explained the challenge of finding a balance between achieving a positive social experience and delivering a professional, clinical physiotherapy service.

Definitely a professional sort of relationship but they have to feel comfortable as well so you have to relate to their level. Um, and actually from previous experience as well, so seeing a physio that can sort of

remember things that you enjoy or whatever, or have a bit of a chat, it's great you know, it feels a little bit, nice to have that, but it's a fine line though isn't it between how much – just that professionalism.

(Lachlan, physiotherapist participant)

To physiotherapist Donna, casual conversation was considered important in identifying common interests that assisted in building rapport.

Common interests also helps with regards to developing that rapport. Yeah, just being genuine. Genuinely interested in the person as a whole not just as a therapist, and I find with private practice, having your own private practice you need to be interested in the person and what they do, not just that you're um, that you're seeing them as a physio and that's it.

(Donna, physiotherapist participant)

The challenge to incorporate both human and therapeutic elements of interactions was frequently reported by physiotherapists. Casual conversation and occasional laughter were generally understood as a means to assist to make the patient feel comfortable, increase the connection between patient and physiotherapist, and humanize the relationship.

To summarize, physiotherapists outlined different communicative elements that they adjusted with the explicit purpose of enhancing connections with individual patients and improving the patient experience of physiotherapy. Indirectly, communicative changes also assisted physiotherapists to achieve their therapeutic agenda. These adjustments, which I have termed 'adaptations', included active listening, non-verbal communication, touch, casual conversation, and humour. In the second section of this chapter I describe these same adaptive elements arising from analysis of observational data and situate these elements within the broader physiotherapy and healthcare communication literature.

Physiotherapists perceived that they needed to adapt their communication in order to optimize each individual patient's experience of physiotherapy. Implementing these adaptations, however, required a nuanced understanding of the subtleties of each individual patient. In the following section I elaborate on the specific individual patient characteristics that prompted physiotherapists to make adaptations.

Adapting in response to individual patient characteristics

Physiotherapists indicated that they purposefully changed elements of their communication in response to individual patient characteristics. Specific patient characteristics, behaviours, and needs were either implicitly perceived or explicitly stated by physiotherapists to trigger adaptive changes. These characteristics and needs included patient expectations, cultural and socioeconomic backgrounds, personalities, demeanours, and clinical presentations. As they explained the reasons for changing elements of their communication, physiotherapists also spoke further about adaptations as a means of understanding their patients and making connections with them.

As examples, physiotherapists Simone, Clint, and Tommy stated that they were adaptable and flexible in their communication. They explained that adaptations were in response to patients' expectations, wants, and likes.

I try to adapt according to what the patients want. So, it's not just purely on, you know, treating that aspect of the injury but try to treat the patient as a whole I think. In regards to what they expect and what they really want and what they like and what they dislike and things like that.

(Simone, physiotherapist participant)

I do it differently every time, based on who comes through the door. It needs to be flexible.

(Clint, physiotherapist participant)

Every patient is different, and if they need me to be a big brother relationship, then I will be a big brother relationship, if they want me to be a more teacher/educator relationship then I will be a teacher/educator relationship. If they need me to be a father relationship I will be a father relationship, if they need me to be a friend in the relationship, I would be. So I can change my role, depending on what is needed.

(Tommy, physiotherapist participant)

Examples of how physiotherapists adapted to patients of varying ages, cultures, personalities, and socio-economic backgrounds, and those with different clinical presentations were provided. Physiotherapist Simone identified social differences and patient personalities as patient characteristics that prompted her to adapt.

We have to treat everyone differently because of different upbringings, social differences.

(Simone, physiotherapist participant)

Like those that are assertive, you have to be assertive to talk to them and not be really passive or you'll be overwhelmed by them. For those that are very passive you have... to stir them up a bit to get them talking so that you interest them a bit more so that they will want to talk more in a sense.

(Simone, physiotherapist participant)

Extending the idea of using patient personalities to assist his adaptive communication, physiotherapist Lachlan explained how each patient's

demeanour and body language assisted him to decide when and how to change his communication.

It's more sort of working out her body language and those sort of things and that will kind of determine how I then go. You can't be hugely bubbly all the time and happy when things – you have to sort of get to their level and then take it from there so that's why it can sort of vary, you know, someone's coming in... you just have to sort of gauge it and just change.

(Lachlan, physiotherapist participant)

Physiotherapist Kate implied that she tailored communication to a patient's psychosocial aspects.

I like to have a good relationship, I want to know what's going on in their life... if there's a reason why they're coming in with pain. It's usually due to their stress at work or at home or something like that so I think I know them fairly well – I'll tailor it to where they're at.

(Kate, physiotherapist participant)

As a further example of adapting communication in response to patient characteristics, physiotherapist Tommy spoke about being flexible in response to patients' clinical presentations.

I would also change my technique for patients who are hampered by other conditions like, if they have lots of central sensitization that's um that's impeding their process, I would change in terms of telling them not what is wrong but what can be done right... Not telling them what is bad about their knee but telling them what is good about their knee um, yeah, really changing the words whenever I feel would suit the patient and

whenever I feel that the patient is responding to that style.

(Tommy, physiotherapist participant)

Each of the examples provided in this section highlights patient characteristics that were explicitly stated by physiotherapists to engender an adaptation in their communication. In addition, physiotherapists suggested that adaptations often occurred implicitly. I next describe the physiotherapists' perception of the intuitive nature of many adaptations.

Intuitive implementation of adaptations

Many physiotherapists spoke about an intuitive component to the adjustments that occurred during their interactions with patients. While there were instances when they made conscious decisions to change, and could provide a rationale for their decisions, many of their adaptive behaviours relied on intuition. Words used by physiotherapists such as 'tailoring', 'instinct', 'perceptions', and 'gauging' suggested that intuitive responses were part of their approach to interacting with patients. Internal senses or values therefore contributed to the responsive adjustments that physiotherapists reported making when they interacted with patients.

Physiotherapist Caroline described a subconscious clinical reasoning process that resulted in tailoring the interaction to the patient's needs.

I think that's also what we're good at, tailoring it to a person and I think all of that non-verbal and their biggest story, you know, I think we bring that into our clinical reasoning, and maybe we aren't realizing we are doing it as well.

(Caroline, physiotherapist participant)

Similarly, many physiotherapists believed that as physiotherapists they had a natural ability to 'read' and understand their patients and to adapt accordingly. They described this intuitive or perceptive skill as an ability to gauge cues from the patient. It mostly involved consideration of non-verbal communication. Physiotherapist Lachlan noted varying and changing aspects of his communication based upon his perceptions of the patient's non-verbal communication. He emphasized his view that these adaptations were instinctive and natural for physiotherapists because of their experiences in interacting with people.

You just have to sort of gauge it and just change. I think it just comes naturally... to most, to physios that are always interacting with people.

(Lachlan, physiotherapist participant)

Three further quotations from physiotherapists highlight that intuition regarding the use of touch was particularly important when interacting with patients.

Perception of a patient's personal space and comfort before initiating touch was important to physiotherapist Clint.

I've had many occasions when I wouldn't touch someone for an hour in an initial assessment – that's based on my perceptions as to their personal space, as to the threat of the situation and of their past experiences. And it might be more important to help to take the threat out. You really need to read that and work out what are the barriers, where is their safe place and then just how to edge in there.

(Clint, physiotherapist participant)

Physiotherapist James noted that intuition was important when asking patients to dress and undress. He implied that the patient's response to being asked to remove clothing provided him with cues that he intuitively followed.

You can sometimes pick up on people who are a bit funny, and say for me being a male, if a fem... Say I'm treating someone who needs, who I would need them to take their top off, um, I would, sometimes you pick up on people who are, yep (*snaps fingers*), no problems in doing it and some people who are a bit, like, 'mm what's going on here?' and then I would generally use touch less with them because they, obviously they are a bit unsure until they become comfortable or you can sense that they become comfortable, I think you can, I sense that I'm... I think I am ok at picking up people who you can use touch and use it whenever you need to and some people who don't like it or who are unfamiliar with it or haven't been to physio before.... Or who don't understand why you're doing it.... Whether it be that they just don't want you to touch them, and then you can explain why you are doing it, but I think you can definitely pick up on people who can, who will or will not like that and occasionally you don't and then they probably don't come back.

(James, physiotherapist participant)

As a final example, Lachlan insinuated that intuition regarding touch is heightened for male physiotherapists due to perceptions about possible sexual harassment associated with touching female patients.

With some patients I instinctively step back a bit, and that's particularly being a male as well, I think you have to be very careful with that. Sometimes that's just put on guard a little bit more depending.

(Lachlan, physiotherapist participant)

An intuitive ability to adapt was therefore considered by physiotherapists to be beneficial as a means of maintaining ethically appropriate interactions. A further benefit of adapting intuitively involved achieving flow and flexibility within the interaction. Physiotherapist James described how it is awkward if the physiotherapist is constantly asking questions and ploughing through the clinical agenda without gauging the patient's response.

You're trying to do your proper assessment and manual treatment and get a good gauge on what their, what's happening when you're doing things. It's awkward if you're just simply going 'what, what is this feel? where are you feeling it?' all the time.

(James, physiotherapist participant)

James also explained how a rigid approach may limit the information received from the patient, and noted that it can depend on the individual and that it requires some experience to learn the art of knowing how and when to adapt.

I think I've sort of tended to move away from 'tell me', like really instruction like 'tell me where your pain is,' 'tell me where your aggravators are', 'tell me what your eases are'. I mean, I still ask those but not so like, not so rigid. Because I think you don't get enough information if you just do it that way. And I think sometimes you can, and it depends on the person as well, you can sort of, I think some people you really need to be quite strict, not strict but quite umm... I s'pose... What's the word? Umm... I think you've got to be more stringent in terms of what you ask because otherwise they'll just talk forever whereas some people seem to just tell you what you want without having to prompt them, so it really just depends on the individual, I don't think you learn that until you've

seen a few people and, I think this is more nuances you pick up along the way, things you need to ask a bit more about.

(James, physiotherapist participant)

Even though physiotherapists considered that they had a perceptive ability to adapt, they also acknowledged that it was often a process of trial and error and that they did not necessarily get their chosen style or adaptation right the first time. Physiotherapist Simone explained how she tried different approaches with her patients.

You really have to, it's hard to say, it comes with experience I think, you know, when you first see the person or you first greet the person you roughly have an idea of what sort of person that, that patient is. So you just try and, you know try this out and if it doesn't work try this, if it doesn't work back off. You know.

(Simone, physiotherapist participant)

In summary, physiotherapists were very aware that they were adjusting their communication, but acknowledged that choosing the specific strategies of when and how they adapted was often intuitive. They believed that adapting non-verbal behaviour, especially touch, relied on intuition or on a subconscious awareness of patient expectations and comfort levels. There was also a sense that this intuitive ability to gauge the needs of the patient and adapt accordingly, was related, at least in part, to the level of experience of the individual physiotherapist.

These findings extend those of Ajjawi and Higgs (2012) who suggested that the process of how physiotherapists communicate clinical reasoning is largely automatic. Other similarities between my findings and those of Ajjawi and Higgs (2012) are the use of active listening and a process of 'matching the co-

communicator' (p.114). Similar to the way that physiotherapists in my research described adaptations, physiotherapists in the research about communicating clinical reasoning explained that they used a dynamic, intuitive process of evaluating cues to try to understand the needs and perspectives of their audience (either patients or other learners). Subsequently, these experienced physiotherapists adjusted their communication to try to match their audience's needs and perspectives (Ajjawi & Higgs, 2012). My findings, from physiotherapist participant interviews in the private practice setting, indicate that the previously described process of adjusting to, and matching the co-communicator to convey clinical reasoning, is also used for caring and empathic aspects of communication. My results therefore extend knowledge about the use of these automatic adaptive elements of communication into the caring, empathic aspects of practice and the private practice setting.

In my study physiotherapists mentioned that experience interacting with people was an important part of the skill of adapting their communication. In her seminal work on the development of expertise, Benner (1984) explained that during the expert stage of practice, intuition often replaces conscious consideration. It is therefore likely that intuitive adaptations are a component of expert communicative practice. Paley (1996) later proposed that it is difficult to specify the basis for intuitive decisions and the resulting changes. This makes intuitive aspects of practice difficult to teach. Assuming adaptive communication is an intuitive and essential part of physiotherapy practice, this poses a challenge for professional education. Perhaps, as Gyllensten and colleagues (1999) suggest, reflective processes for physiotherapists may assist. I address differences between novice and experienced physiotherapists and provide considerations for physiotherapy education and the role of reflective practice in Chapter seven.

Other investigations in different settings have considered how physiotherapists perceive their interactions with patients. Physiotherapists in other studies have similarly expressed the view that they see themselves as caring and as demonstrating emotions such as interest, joy, and sadness in their interactions (Cromie, Robertson, & Best, 2002; Gard et al., 2000). In a Swedish study of physiotherapist perspectives about factors influencing quality of interaction, features of the 'interaction dimension' theme included: 'being sensitive and intuitive', 'listening', 'acknowledging body language and facial expressions', and 'taking in the whole' (Gyllensten et al., 1999, pp. 98-99). These results correlate well with my findings, suggesting that physiotherapists perceive that their interactions involve attentive and responsive human elements incorporating caring, empathy, and connection. It is possible that the 'humanistic values' that physiotherapists have described constitute the underlying attitudes required for adaptive communications to occur.

Physiotherapists also concentrated on achieving their therapeutic agenda and maintaining professionalism during their interactions. This was particularly evident when they described their use of casual conversation as friendly yet professional. Physiotherapists actively worked to offer care and empathy for each individual patient while providing a professional, therapeutic service.

In the following extract, physiotherapist Clint explained how he juggles the caring and clinical aspects of his interactions by adapting his communication style. He outlined the intersection between achieving a collaborative partnership and connection with patients, together with the need to be respected as a knowledgeable professional who has reputable skills.

I definitely like to be very calm in the first, the first few goes until I have a hunch as to, I mean I really try and read the other person very, very well

and try to pitch it at the level that is meaningful. So that, if I need to go a little bit crazy, I can ramp up to that, if I need to continue that sort of calm sort of thing throughout the whole thing, or if I need to just be down swearing in the gutter, then, you know, that's the way to go as well. So, my style I guess, this sounds really dodgy, is really trying to read what, what, who you need to be, to get through. What role do you need, or what persona do you need to take on to be in a meaningful situation where they can embrace your ideas but still respect, and still come from a position of knowledge.... You need to get them confident, you need to get them respecting your areas and your skills but also know that you are in there one-on-one with them and it's not an unequal therapist-patient sort of dynamic, that it's quite an equal sort of thing and that they, their words are the words that we use. So, if they give me particular terminology then I want to know about that and I want to find out more, and ideally I'll try and pitch my stuff within that framework and try and find things that are really meaningful that are gold for them – that just demonstrate that I have an understanding of, that it's real.

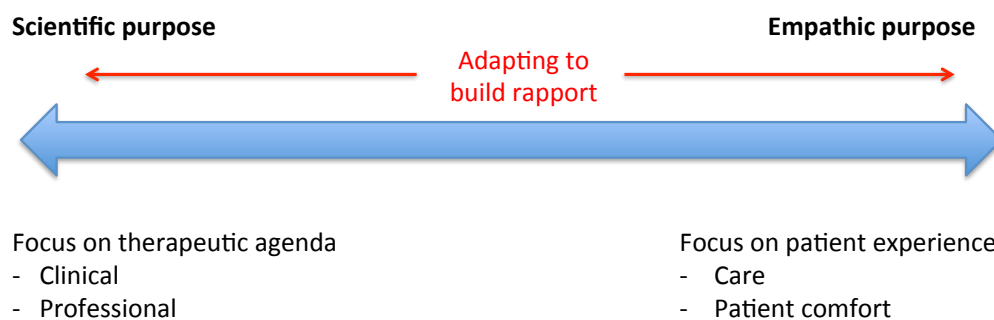
(Clint, physiotherapist participant)

In effect, this quotation summarizes the ideas presented in this section. Clint described an equal partnership or relationship based upon respect and explained the need for human and therapeutic aspects of the interaction to occur simultaneously. This explanation reinforces the results from the physiotherapist interviews presented in Chapter four where I concluded that each physiotherapist had a sense of purpose that could be placed along a continuum between a focus on the therapeutic agenda and a focus on the patient experience.

In light of these results, I propose that the adaptive communication that physiotherapists described in this section occurred along the continuum

presented in Chapter four (see Figure 7). Adaptive communication allowed physiotherapists to achieve their scientific purpose as well as their empathic purpose. As demonstrated in Figure 10, physiotherapists were sensitively and continually adapting to build rapport and to allow appropriate incorporation of both their clinical and their caring focuses. That is, both scientific and clinical purposes were integrated within the one interaction via a process of adaptation.

Figure 10: Physiotherapists adapted along the spectrum of communicative purposes



As I have emphasized in this section, most physiotherapist adaptations reflected a concern for the patient's experience of physiotherapy. Almost certainly this was because physiotherapists' underlying communicative strategies were frequently centred upon the achievement of clinical tasks, as presented in Chapter four. In Chapter six I progress these ideas and use a relationship-centred approach to discuss how physiotherapists incorporated both scientific and empathic purposes into their interactions with patients.

To summarize this section, I have used data from physiotherapist interviews to introduce the concept of adaptive communication. Findings from the data have been used to describe how individualized adaptive communication added a responsive human element and developed rapport between patients and physiotherapists as they interacted. In the second section of this chapter I

describe elements of adaptive communication that I observed occurring in patient-physiotherapist interactions. These adaptive elements mirror those described by physiotherapists in their interviews and functioned to build a connection between patient and physiotherapist. The direct correlation of observational data with the physiotherapist interview data consolidates the theme 'adapting to build rapport'.

Adaptive communication was observed to build rapport

This section of Chapter five presents elements of adaptive communication derived from analysis of observational data. These elements are divided into three components: body language and eye contact, touch, and casual conversation and humour. Within these three components I reproduce field notes and transcripts from observational data to demonstrate how communication was adapted during patient-physiotherapist interactions. Although physiotherapists were responsible for the majority of adaptations, patients were also observed to add or adjust aspects of communication. From the field observations there appeared to be a connection occurring between patient and physiotherapist that provided observational evidence for the positive effect of adaptive communication on the rapport established between the patient and physiotherapist.

Body language and eye contact

Eye contact, nodding, and other forms of non-verbal communication were incorporated and adjusted throughout the observed encounters. Recognizing that non-verbal communication occurs continuously, I suggest that eye contact and body positioning were deliberately modified throughout patient-physiotherapist interactions. Whether conscious or subconscious, I consider that

these aspects of communication assisted to build and sustain rapport by positively impacting on the human and professional connections between patient and physiotherapist.

Field notes that described non-verbal aspects of the interaction conveyed the significance of non-verbal communication in forming a connection between patient and physiotherapist. For example, in my field notes I described the behaviour of physiotherapist Lachlan in the following manner:

He [physiotherapist] leans in toward patient to listen/hear/look/connect.

Leaning in, nodding, making eye contact, and matching postures were all non-verbal components of interactions that assisted to establish a connection, seemingly by demonstrating genuine care and reflecting feelings and thoughts between patient and physiotherapist.

Making direct eye contact was a communicative element commonly used and adapted by physiotherapists. Eye contact appeared to allow the physiotherapist to gauge and understand the patient's experience during the interaction. I provide three examples illustrating the use of eye contact.

First, physiotherapist James made eye contact and looked at his patient Melanie's face while he was assessing her knee. Adapting to incorporate this eye contact provided him with information about Melanie's experiences during his assessment.

James: How's that underneath in there?

Field notes: palpating/moving the patella >looks up at patient face

Melanie: Just a little sore.

James: And there? *(looks again at patient face)*

Melanie: That's fine.
James: So it's a lot better isn't it?
Melanie: Yeah it is.

(Physiotherapist James, observation 6)

Aligning non-verbal and verbal communication enhanced the understanding between the two interacting.

Secondly, eye contact was used to emphasize an important point or message being conveyed between the two interacting. As stated in the field notes, physiotherapist Donna used purposeful eye contact to show her patient Jill that she genuinely meant her statement: 'you're doing really well'.

Donna: You're doing really well, um, can I ask you to bring your feet together please and eyes opened – these do get harder.
Jill: Great.
Donna: You're doing really well. So far, so good.

Field notes: 'doing really well' = strong eye contact with patient > physiotherapist standing now and watching.

(Physiotherapist Donna, observation 2)

Thirdly, physiotherapist Lachlan used eye contact and adapted his posture to match that of his patient, Hannah. These adaptations demonstrated Lachlan's openness and willingness to actively listen, and subsequently helped achieve a connection and understanding between patient and physiotherapist.

Field notes: Eye contact ++ from physiotherapist > same posture in the chair.

Lachlan: I've just had a bit of a read of the notes, but in your words, um, what have you, what did Alison [pseudonym for another physiotherapist] get you doing?

Hannah: Um, ah, so, the extra thing that, so she had me doing the same things.

Lachlan: That we did?

Hannah: Which is the standing up and the...

Lachlan: Yeah.

(Physiotherapist Lachlan, observation 3)

At the same time, patients often nodded and adapted their posture to listen or to understand the physiotherapist. Field notes described patient Emily's attentive and engaged non-verbal communication.

Field notes: Patient nods, patient head to side when listening to physiotherapist questions.

Lachlan: Have you tried um, any sort of, heat, or anything like that?

Emily: Oh I guess, yeah, the heat pack.

Lachlan: Yeah.

Emily: That's it.

Lachlan: Yeah. Okay. It's hard isn't it when it's that sort of, just that nagging

Emily: Yep.

Lachlan: Pain and... Yeah. I can imagine it would be (*softly*). Alright, so, when you do sort of feel it come on and you go for your break and you might get out of that do you sit down or do you stand up for your break?

(Physiotherapist Lachlan, observation 5)

Further field notes from this interaction indicated physiotherapist Lachlan's use of eye contact.

Making a connection by using eye contact and relating himself to the patient situation.

(Physiotherapist Lachlan, observation 5)

In their interaction, Emily and Lachlan were actively engaged in the tasks and conversation as evidenced by their non-verbal communication of eye contact, nodding, and body positioning.

I note here that this same transcript of interaction between Lachlan and Emily was presented in Chapter four as an example of a physiotherapist redirecting the content of communication back to the physical agenda. These different communicative features captured in the same excerpt of an interaction highlight the complementary nature of physiotherapist-led and adaptive communication: both were occurring concurrently.

Non-verbal communication was an intrinsic and constantly occurring element in patient-physiotherapist interactions. As an observer, I frequently sensed moments when non-verbal communication had purpose and intent, tending to soften the more directive, clinical components of the interaction.

Physiotherapists and patients used eye contact or body language to draw the other toward a particular characteristic. For physiotherapists, this was often to emphasize clinical components of the interaction, or to provide a clear demonstration of their willingness to actively listen. For patients, it was usually to capture the physiotherapist's attention or to acknowledge or accentuate a point. Eye gaze has been recorded as the most frequent non-verbal behaviour used by patients when interacting with physiotherapists (Roberts & Bucksey, 2007). It appeared to me as the observer that the response to non-verbal communicative adaptations was engagement and understanding between the two interacting.

Given the significance of non-verbal aspects of communication, historically there has been relatively little research in this area, especially when compared with

verbal communication. (Finset, 2007; Roter, Frankel, Hall, & Sluyter, 2006). There has, however, been a recent increase in healthcare research exploring aspects of non-verbal communication during patient-practitioner interactions. As examples, studies have explored eye gaze during patient-physician interactions that used electronic health records (Asan, Young, Chewning, & Montague, 2015), the importance of a forward leaning body position and increased use of gestures in the general practice context (Little et al., 2015), and the benefits of doctor and patient having eyes at the same level and being in close physical proximity (Kozimala, Putowski & Krajewska-Kulak, 2016). These studies each convey the significance of non-verbal communicative features in patient-practitioner interactions.

Non-verbal communicative components are considered central to the nature of the relationship between patient and practitioner (Roter et al., 2006). My observational research results, along with those of other researchers, show that eye contact from practitioners is linked to connectedness and an increased patient perception of clinician empathy (Montague, Chen, Xu, Chewning, & Barrett, 2013). In coordinated combination with speech, eye contact is a means for clinicians to demonstrate an engagement and interest in the patient's story, and aligns with increased clinician awareness in psychosocial aspects of a patient's presentation (Bensing, 2000; Gorawara-Bhat & Cook, 2011).

Non-verbal communication has rarely been incorporated into physiotherapy research. Thornquist (1991) has provided the most detailed exploration, explaining the continuous process of non-verbal or bodily communication between patient and therapist. My data included direct eye contact that has previously been discussed as a technique used by physiotherapists to convey the availability and engagement of the physiotherapist (Thornquist, 1991). The role that a physiotherapist's surveying gaze played in achieving an awareness that

precipitated adaptations was highlighted thus: '[a] continual awareness of what is happening is a prerequisite for adapting to the patient's reactions — for deciding what to do and when' (Thornquist, 1991, p. 192). Thornquist's comment about physiotherapists 'adapting to patient's reactions' is demonstrated even more strongly in my research that both specifies the types of adaptations that occur and the purposes of these adaptations in patient-physiotherapist interactions.

Also considered a form of non-verbal communication, touch was frequently adapted by physiotherapists as they interacted with patients during the observations.

Touch

I previously noted that there were two types of touch used by physiotherapists: technical touch as part of assessment or treatment, and caring touch that conveyed empathy and interest in the patient as an individual. As the observer, I was often emotionally engaged during moments when touch occurred. Both types of touch were observed as adaptations within patient-physiotherapist interactions and created a sense of engagement and connection between the two interacting. Below I outline adaptations involving touch that I observed during the interactions.

When performing technical touch as part of assessment and treatment physiotherapists often adjusted their touch by changing the position or pressure of their hands. Physiotherapists' hands appeared to respond to patients' verbal and non-verbal reactions to their touch. This responsiveness correlated with an increased rapport between the two. Field notes written while observing physiotherapist Kate with patient Catherine suggest that a connection occurred between patient and physiotherapist when technical touch was used in the

interaction.

She [physiotherapist Kate] places her palms and fingers broadly on the patient's body before settling on where she wants to palpate. The palpation is sensitive, yet firm and purposeful. She occasionally asks the patient to verify her feelings (what she feels through her hands). Once she settles on a specific treatment, the touch becomes very rhythmic, it is relaxing, consistent and provides a connection between the two interacting.

(Physiotherapist Kate, observation 3)

This type of responsive, connective technical touch was observed frequently. During her interaction with physiotherapist Simone, patient Rachel commented on the pain she experienced, and Simone replied verbally with 'very gentle' as her hands simultaneously adjusted to Rachel's cues.

Rachel: Ah he he he he... Ohhh that's really sore (*in a pained expression*) ah he. So um.

Simone: Very gentle (*hands observed to soften and slow in response*).

Rachel: Thank... Yes you are Simone. Ah he he. I just know my, my um, muscles are sensitive. (*3 secs*) As I said I wouldn't come back if I didn't have full confidence with you (*5 secs*) and I know in the end it feels better in the long run you know. Ah he he (*laughing again*).

Simone: Ah (*slight smile*).

(Physiotherapist Simone, observation 3)

Technical touch was also a tailored addition during exercise prescription. Touch as part of education and exercise prescription provided a connection by assisting the patient to feel and understand the desirable position and the movement. As occurred frequently in interactions, James used technical touch to facilitate his instruction about a squatting exercise for his patient, Melanie.

Field notes: Physiotherapist places hands on each part of patient's body > hips, back, leg, etc. Very deliberate.

James: So knees slightly bent, over that second or third toe, just make yourself tall through here, so don't arch too much, so just curve your back a little bit. Other way, so come forwards, yeah that's better, and place your weight over your heel but just bend the knees slightly.

Melanie: Oh I can feel that a lot.

James: Can you?

Melanie: Yeah.

James: So just, just make sure you keep that.... What will happen is that when you tire you will sink.

Melanie: Okay.

James: So make sure you keep your belt line straight, so this stays nice and strong and you're just putting your weight through your heel.

(Physiotherapist James, observation 6)

During this exchange, I recall that James continually adjusted the position of his hands to facilitate the exact movement that he wanted Melanie to perform. As his hands moved and changed their position, Melanie increased her awareness of the exercise and her body as she stated: 'Oh I can feel that a lot'. Touch facilitated a mutual understanding that formed a bond between patient and physiotherapist.

These examples clearly demonstrate that technical touch was adapted.

Physiotherapists used touch to demonstrate both awareness and responsiveness to the patient's experience and needs, frequently resulting in increased rapport between patient and physiotherapist.

I refer to the second type of touch used during interactions as 'caring touch'.

Caring touch was not part of the clinical physiotherapy assessment or treatment, and seemed to be used to convey care and to empathize with the patient. Touching the patient's leg during an explanation, or rubbing the patient's shoulder were common examples of caring touch. Moments of caring touch appeared to bring the patient and physiotherapist together, connecting and uniting them in a common goal. During their interaction, physiotherapist Donna rubbed her patient Jill's legs to show that she understood Jill's frustrations and to demonstrate that she cared.

Donna: Does that make sense?

Jill: Yeah.

Donna: *(Sighs)* We're going to get there. Hmm I know how frustrated you are.

Field notes: 'We're going to get there' and rub on patient's legs. Hear the touch – tone changed in voice when touching.

Jill: That'd be good.

Donna: I know you have been through a journey, in terms of getting your neck and stuff like that but you know what, I really think you're – we're almost there.

Jill: Okay.

Donna: And you can do it.

Jill: Yeah, I'll be right after a holiday.

(Physiotherapist Donna, observation 2)

The caring touch on Jill's legs accompanied a concurrent change in the tone of Donna's voice. I recall that the feeling in the room changed at the moment the touch occurred, and there was a palpable emotional connection aided by a deeper understanding between Donna and Jill that they were working together. The use of touch had both supported and enabled rapport between the two.

In another example, my field notes reported that physiotherapist Tommy noticed tension in his patient Marissa's hand while he was treating her, and touched it as he asked her to relax.

Field notes: Physiotherapist notices patient's left hand gripping and touches it along with his verbal communication.

Tommy: So, so do you try to – just relax your hand. Is that a bit sore there?
Marissa: Yep.
Tommy: If it's too sore just let me know, yeah.
Marissa: Yep.

(Physiotherapist Tommy, observation 7)

Through caring touch and the verbal request to relax, Tommy displayed empathy by showing Marissa that he was aware of what she was feeling and was responding to her needs.

I have presented two channels of engaging patients through touch. The first was adapting technical touch such as massage and mobilization in response to the patient's experience of therapy. This type of technical or therapeutic touch has long been central to the physiotherapy profession (Nicholls & Holmes, 2012). A connection was also made through the provision of additional caring touch that was not part of the therapy. Other authors have recognized caring touch as part of communication used in physiotherapy (Helm et al., 1997; Roger et al., 2002). My results contribute to this literature by confirming that similar types of touch are used in the private practice setting, and by increasing the evidence that physiotherapists extend their use of touch into the personal domain through a type of caring touch.

Touch is recognized as a fundamental sense and is described as a powerful means of communicating (Durana, 1998; Hertenstein, Holmes, McCullough, &

Keltner, 2009). Touch can mediate physiological changes and has demonstrated pain-relieving effects (Field, 2010). Emotions such as fear, gratitude, and sympathy can be portrayed through touch (Hertenstein et al., 2009). Touch is therefore a powerful tool that physiotherapists incorporate into their interactions with patients to achieve multiple physical and emotional responses. My findings, in the physiotherapy context, highlight the ability for empathy to be conveyed through touch and contribute to knowledge about the ways in which touch can build and sustain relationships.

However, as a counter to the positive effects of touch, there is also concern about using touch in healthcare settings: this has been labelled the 'touch taboo' (Durana, 1998). This 'taboo' involves the risk of overstepping professional-patient boundaries with intimate touch, particularly between male therapists and female patients. A possible loss of objectivity on the part of practitioners, and the reinforcement of unequal power relationships through touch, are reasons for the touch taboo (Durana, 1998). The touch taboo has potentially subdued the impact and influence of touch as part of therapeutic exchanges. Professions such as psychotherapy have traditionally advocated the avoidance of touch, and continue to have reservations about its use in practice (Durana, 1998; Phelan, 2009; Stenzel & Rupert, 2004). The physiotherapists in my study spoke of their awareness of the ethical concerns about touch, but there were no observed or reported negative incidents relating to touch during the research. Physiotherapists in a Canadian research project exploring touching styles also stated that they had not experienced negative instances associated with the use of touch in physiotherapy (Helm et al., 1997). It is possible that physiotherapists have negotiated the challenges associated with the use of touch in a way that allows them and their patients to benefit from its positive impact on communicating emotion, empathy and competence.

Historically, physiotherapy has embraced touch as part of its healing practices.

Although the potential intimacy of touch may have partly limited its use, touch has been deemed a vital, distinguishing, and defining feature of physiotherapy practice and remains a frequently used treatment and communication method (Bjorbaekmo & Mengshoel, 2016; Helm et al., 1997; Nicholls & Holmes, 2012; Roberts & Bucksey, 2007; Roger et al., 2002). My results strongly support previous findings that physiotherapists actively seek opportunities to use both technical and caring touch as an adaptive means of demonstrating empathy and care for patients.

A special connection has been described by researchers observing and patients experiencing touch in healthcare settings (Bjorbaekmo & Mengshoel, 2016; Hyland, 2006). A sense of unity and understanding between two people interacting can exist in situations where an unspoken awareness through touch presents as a 'silent, touching, moving dance' (Bjorbaekmo & Mengshoel, 2016, p. 16). My field notes on physiotherapist Kate performing manual therapy indicate that her technical touch was indeed communication and responsiveness in motion. In my research, an unspoken dialogue occurred between physiotherapist and patient through touch that formed the type of special connection that other authors have proposed.

Phenomenological insights also assist to explain my observations of the empathy and connectivity that touch conveyed. Van Manen (2014) describes a pathic sense as an 'experiential understanding' (p. 268). Pathic knowledge, such as that expressed in empathy and sympathy, is a way that we might understand others through sensing and experiencing (van Manen, 2014). I suggest, as have Bjorbaekmo & Mengshoel (2016), that van Manen's notion of pathic touch is present in patient-physiotherapist interactions as a powerful means of conveying care and empathy. There is an intimacy and sensitivity about pathic touch that provides support, understanding, and connection. When enacted, pathic touch provides an appropriate pressure that is subconsciously known by

the practitioner and subsequently understood by the receiver. Pathic touch, occurring in patient-physiotherapist interactions as both technical and caring touch, therefore assists to build a connective rapport.

My findings presenting touch as a responsive, adaptive element of patient-physiotherapist interactions therefore correspond closely with other descriptions of touch in sociological and healthcare literature. To my knowledge, my findings provide the most detailed account of touch occurring in the private physiotherapy setting to date. These descriptions and associated understandings further our knowledge about touch in physiotherapy practice. It is apparent, from the amalgamation of my findings with those of other authors, that touch is an effective and influential communicative medium that conveys empathy and supports the development of a harmonious relationship. This is significant for development of both practice and education in the physiotherapy profession.

Casual conversation

I observed patients and physiotherapists engaging in casual conversation during their interactions. Casual conversation was friendly chatter or banter and included content that covered social aspects of both the physiotherapist's and the patient's lives. Topics of conversation ranged from families, the latest news, current affairs, and football, to food preparation, and other aspects of daily life. This social discourse punctuated the physiotherapist-led structure and focus on physical aspects during interactions. During periods of casual conversation, patients and physiotherapists appeared relaxed, comfortable, and less formal. Casual conversation seemed to create an affinity between the two people interacting. It was a communicative adaptation of the physiotherapist-led clinical agenda, mostly initiated by the physiotherapist, which functioned to build and maintain a positive relationship.

The following three extracts illustrate the lighthearted, jovial conversations that occurred as variations in the usual discourse during patient physiotherapist interactions. In the first example, at the start of their interaction, physiotherapist Simone and patient Rachel enjoyed a conversation about Simone's flat car tyre.

- Rachel: Oh nooo! (*Muffled words indicating sympathy*)
Simone: I just drove it up the, the, you know the driveway and the buop, buop, buop (*gesturing bumping of a flat tyre*) you know like.
Rachel: Ah he he//... (*Both laughing loudly*)
Simone: //He he. (*laughing*)
Rachel: Oh, oh dear... Oh it can only get better. (*More laughter from both*)
Simone: I dunno what I'm going to do with that.
Rachel: Oh dear.

(Physiotherapist Simone, observation 3)

Field notes associated with this transcript stated:

Physiotherapist happy to say about car tyre and things not being good > indicates something of relationship.

(Physiotherapist Simone, observation 3)

The notes also described the interaction as '*warm and chatty*'.

In a second example, physiotherapist Clint similarly commenced his treatment session with casual conversation. Following casual conversation, the clinical discussion had a relaxed and collaborative feel as patient Robyn initiated some conversation and described her feet as being 'naughty'.

- Clint: That's it, she's in for the bubbles and for the glass studio display. If you're into glass art. One of the people I see has a relative who's a

glass artist and, and they're doing the art thing. But enough about that.

Robyn: They've been alright, they've been a bit naughty.

Clint: They've been a bit naughty.

Robyn: This one's been red a bit, it's a bit red today and this one, to be honest with you has been so painful on the ball of it that I've found it very hard to use the ball this week.

(Physiotherapist Clint, observation 4)

As a third example, physiotherapist Donna engaged in casual conversation as she farewelled her pregnant patient, Chloe, at the conclusion of their interaction.

Donna: Good-o. All the best my friend.

Chloe: Thank you.

Donna: So there'll be two of you when I see you next? Ha ha ha.

Chloe: Yeah, another girl, apparently.

Donna: Oh really, oh wow!

Chloe: Yeah.

Donna: What name, what have you got? Charlie?

Chloe: Nup.

Donna: C'mon! Then you can read the same book to the same kids!

Chloe: Nah.

(Physiotherapist Donna, observation 4)

Humour

Laughter and humour were often injected into the casual conversation. I commented on humour in field notes related to an interaction between physiotherapist Lachlan and patient Emily.

This physiotherapist uses humour in the same way that most seem to – to laugh about common everyday things. This helps them seem the same as patients. That they understand and experience the same things and can laugh about the same things together.

(Physiotherapist Lachlan, observation 5)

My notes indicate the role that casual conversation and humour played in patient-physiotherapist interactions in private practice, that of bringing people together, and sharing common experiences about life. Sharing and laughing together was another communicative variation that occurred during patient-physiotherapist interactions and assisted to build rapport. Perhaps surprisingly, many episodes of humour observed in the interactions were initiated by patients. For example, patient William and his physiotherapist Lachlan shared a joke about golf.

Lachlan: How many games of golf do you play a week?
William: Two.
Lachlan: Two?
William: Yeah.
Lachlan: So even, and do you always do eighteen, never nine?
William: Nine's only half a game.
Lachlan: Yeah, yeah, yeah – you're a true golfer aren't you?!
William: Well you don't go there to walk nine holes!
Lachlan: No. Ha ha (*both laugh*) – that's fair enough.
William: You've got to get your money's worth.

(Physiotherapist Lachlan, observation 4)

As the conversation continued, patient William explained why he no longer plays golf with his wife, generating more laughter.

William: No, she overtook me last year. It was quite upsetting.
Lachlan: It's a good idea then just to play on your own with your mates.
William: Well you can swear a lot more!
Lachlan: He he (*both laugh*) – that's good.
(Physiotherapist Lachlan, observation 4)

Hannah, another patient of Lachlan's, also initiated a joke, this time about videos on YouTube.

Lachlan: When you come, I'll get you to actually bring running, all your running gear. We'll actually go outside and have a bit of a run around the oval and those sort of things and I'd like to video you as well if that's alright? Just to put it up on here so no-one else can see but//we can have a bit of a chat about it.
Hannah: //but not, not on YouTube? (*With a smirk*)
Lachlan: No not YouTube! No ah ha ha – that'd be a disaster wouldn't it? Yeah!
Hannah: He he.
Lachlan: No, no YouTube videos but... Yeah ha ha.
Hannah: Thanks! What you mean is... A disaster for anybody stealing my...
Lachlan: That's right, a disaster for yeah, confidentiality purposes! Not... yeah, Yeah... Ah he he.
Hannah: I was thinking more of me and how ridiculous I would look.

(Physiotherapist Lachlan, observation 3)

When initiated by the physiotherapist, casual conversation and humour appeared purposeful and responsive to the individual patient's needs. When initiated by the patient, it seemed to bring the pair together on a common socio-emotional level, potentially reducing the power differential. Such 'casual

conversation' is labelled 'socio-emotional exchange', 'social conversation' and 'non-medical conversation' in healthcare communication literature (Greenhill, Anderson, Avery, & Pilnick, 2011; Mead, Bower, & Hann, 2002). Socio-emotional exchanges are regarded as a component of achieving a positive therapeutic alliance, and have been observed to be valuable in building rapport (Greenhill et al., 2011; Mead et al., 2002). In my data, casual conversation occurred as seamless breaks in clinical conversation, bringing patient and physiotherapist together in a positive alliance as suggested by other authors.

Beach and colleagues (2004) term some aspects of conversation not directly related to clinical conversation as 'physician self-disclosure' (p.911). The examples I provided match Beach and colleagues' (2004) 'categories of physician self-disclosure' (p.913) that were stated as rapport or connection building. The categories of self-disclosure included: humorous personal stories (Simone and Rachel example), casual self-disclosure (Clint and Robyn example), and empathy and legitimation (Lachlan and William example). Physiotherapists in the current research were therefore observed to increase rapport through self-disclosure as an integral part of casual conversation.

Humorous anecdotes have also been considered rapport-building in healthcare literature (Beach et al., 2004). Humour is thought to have the potential to establish positive relationships, normalize abnormal situations, and assist with sharing commonalities between patient and practitioner (McCreddie & Wiggins, 2008). In my study, humour was a positive component of the patient-physiotherapist relationship that provided a departure from the physiotherapist-led, clinical aspects and assisted rapport. Patients, in seeking a positive response from practitioners, have been seen as the initiators of humour (Adamle & Turkoski, 2006). Ideas about humour and casual conversation have rarely been incorporated into physiotherapy literature. My findings suggest that humour

plays a similar role in the physiotherapy setting as in other fields of healthcare: to build rapport and establish commonalities between patient and therapist.

To conclude, in this section I have confirmed that the adaptive elements of communication physiotherapists described in their interviews were also occurring in their interactions with patients. Adaptive communication was predominantly non-verbal: eye-contact, body language, and touch were key elements along with casual conversation and humour. I also conclude that these observed adaptive elements of communication functioned to build rapport between patient and physiotherapist.

The upcoming section of this chapter provides the patient perspective that adaptations assisted to convey care and build rapport within patient-physiotherapist interactions.

Seeking care and rapport: the patient perspective

Throughout this final section of Chapter five I present excerpts from patient participant interview transcripts. Some of the quotations included here are patients' accounts of what they actually experienced during their interactions with physiotherapists; others are descriptions of patient preferences for an ideal experience of interacting with physiotherapists. Patients were generally complimentary of the physiotherapist's communication and had positive experiences of interaction. They did, however, suggest possible improvements related to demonstrating genuine care for the patient and achieving rapport.

The patient perspective is incorporated into this section under three headings. I commence with data confirming that patients were aware of, and recognized the need for, physiotherapists adapting communication in their interactions. As

evidenced throughout this section, patients concurred that adaptive communicative elements were active listening, touch, body language, casual conversation, and humour. Second and third I present the patient perspectives that receiving 'genuine care' and experiencing 'rapport with the physiotherapist' are fundamental elements sought during interactions with physiotherapists. Patients highlighted the need for communication to be adaptive in order to convey individualized care and enhance relationships between patients and physiotherapists. Patients appreciated these outcomes of adaptive communication: experiencing genuine care assisted them to feel a connection and a rapport with the physiotherapist.

Patients perceived that physiotherapists had different styles and adapted to patients' needs

Reflecting physiotherapist interview data, patients recognized that physiotherapists each had different styles or purposes for their interactions that they adjusted for each individual patient. The discussed styles included business-like, scientific, fanciful, and empathetic. Patients Melanie and Robyn characterized the styles of their physiotherapists.

I thought Kate was more business-like and 'let's get to it and get you out of here and get you off to work' and I personally I kind of like that, I think that might not suit everybody but I liked that kind of business-like approach.

(Melanie, patient participant)

I think you have to understand your patient, you know, you may need to be fanciful with one patient but you need to initially understand what motivates them to do their homework, what motivates them to be open

about how they're treating you. Kent is quite scientific, Clint, I always call him Kent, he's quite scientific and I probably like a scientific approach to it.

(Robyn, patient participant)

It was clear that patients were aware that they had individual preferences for the style of interaction that physiotherapists provided.

Patients perceived that understanding the individual patient assisted the physiotherapist to adjust his or her style appropriately. Patients believed that this understanding should incorporate the patient's perspective, mental state, beliefs, needs, and physical symptoms. Patient Robyn was particularly focussed on the idea that physiotherapists needed to understand each patient and to change depending on the individual.

Equally they must see a big range of patients, a huge range of patients. It's a very different kettle of fish for different people.

(Robyn, patient participant)

Well I think if you relate it back to communication you have to, and it's like anything, you have to understand who you are dealing with, you can't treat every patient the same, especially if you are addressing something that requires exercise, that requires a home maintenance programme, if you were just massaging backs and that's all you were doing, it doesn't matter, it's a back – and you'll look at it and clinically say it needs A, B and C. If you are looking at someone from a holistic perspective and you need to heal them or you need to support them to cope with whatever they've got, you have to understand them and unless you do that how do you treat them? Everyone's different.

(Robyn, patient participant)

In addition to acknowledging the different styles and approaches, patients also contributed examples of how communicative adjustments occurred. In accord with an observation that I had made, patient Margaret described her physiotherapist's ability to change and adapt her touch in response to pain during manual treatment.

Margaret: Oh no she adapts. If I find that it is too sore she'll go a bit more gentler, yeah, yeah.

Amy (interviewer): Mmm.

Margaret: Yeah, 'cos some areas could be a bit tender. More tender than...

Amy: Yep.

Margaret: Yeah, other times so... Yeah she adapts. A ha ha (*Laughs, both smile*).

Amy: So there's a lot of communication// going on during...

Margaret: //She knows... Yeah.

(Margaret, patient participant)

Margaret's description outlined how the physiotherapist used an acute sense of feel and responsiveness to adapt her hand pressure. In addition to this example, other forms of adaptation such as casual conversation and humour were alluded to in patient interviews, supporting data presented in the earlier sections of this chapter.

In addition to patients being aware of adaptations occurring in their interactions, patients also acknowledged the genuine care and connections that their physiotherapists achieved through adaptive communication.

Patients appreciated the genuine care provided by physiotherapists through adaptive communication

She's got a genuine concern.

(Margaret, patient participant)

He's also empathetic.

(Robyn, patient participant)

Patients regarded demonstrations of genuine care, concern and empathy from their physiotherapists as being a valued part of their interactions, and were disappointed when physiotherapists did not extend this care. Patients reported communicative adaptations such as actively listening and caring touch that physiotherapists incorporated to express genuine care. Equally, patients spoke about being patronized, receiving 'lip service', being rushed, and 'given up on' as physiotherapist communicative behaviours that were lacking in care.

Patients also noticed when physiotherapists invested energy and effort into their role. Patients Margaret and Robyn both compared the experience of an engaged and genuinely caring physiotherapist with that of a physiotherapist who did not endeavour to provide a caring service.

The care and interest in what you are really going through instead of just a bit 'oh well, let's have a look' and off you go.

(Margaret, patient participant)

I think he probably genuinely cares. Like he genuinely cares, like when that work-cover thing, he went to the effort to write stuff where the other person just wrote disjointed crap – I thought 'what?'

(Robyn, patient participant)

Patients recognized touch as a communicative medium that physiotherapists used to demonstrate care. Their interview data resonated with physiotherapist and observational suggestions about touch. Patient Laura described her experience of 'caring touch'.

I've realized that's her kind of style to be like that to rub the knees or rub the back after she's done something, like it's kind of like a mothering thing that she does. And I guess doing that, kind of makes me feel like she cares about me as well.

(Laura, patient participant)

Patients positively linked caring through effort and touch with building friendly and equal relationships between patient and physiotherapist. Patient Laura contrasted a friendly relationship with a particularly clinical one.

And I think Donna's a good – she's good at that, she's kind of friendly and caring and I suspect that she does build relationships with her clients. She's the type of person that's not just super clinical... you know, she's more a bit more friendly and – it works.

(Laura, patient participant)

Moreover, patients recalled experiences when physiotherapists did not demonstrate care. Opposing communicative patterns were described: lack of effort, disengagement, and being patronized. In particular, a sense that interactions were scripted and lacking individual personalization was perceived by patients to demonstrate a lack of care. Patients did not appreciate what they perceived as indifference, a lack of adaptation to the individual, or feeling that they were part of a physiotherapy production line.

Patients knew when the physiotherapist did not extend care, and was not listening or concentrating on their specific scenario. The following examples from patients Robyn and Peter demonstrate an experience devoid of personalized care.

I used to communicate it to the other person and I just got lip service. She really didn't care, that's the reality of it, and don't get me wrong, I know they've got a lot of patients but you can tell if someone does care.

(Robyn, patient participant)

I guess it's in the listening and the responding to 'well it's this' I guess how I would class a bad physio that's not, not really listening to what you've said and they're sort of going through the motions a little bit and well, you know, it's this and I'm just going to get you to do this, this and this.

(Peter, patient participant)

Patients also reported that they were disappointed when physiotherapists used a prescriptive approach and were unwilling to understand and be flexible toward the patient's individual concerns. Patient Margaret described her previous experiences of physiotherapists 'giving up'.

Margaret: They sort of give up on you, in a way that well, you know, 'we can't do any much more for you'. Whereas Simone's gone the extra mile. And she'll really get me going and ah, get me mobile I think so yeah.

Amy (interviewer): So, what does she do that's 'the extra mile'? Can you pinpoint that?

Margaret: Umm, she has a real caring interest in you, whereas the others, okay, you're a patient, let's work out what the problem is and out the door.

Amy: Yep (*softly*).

Margaret: Umm, so that's what I did find a difference in, in Simone. She really is concerned about what your pains are... and how she can improve you the best she can. Instead of, 'okay, really can't do much for you' he he (*high pitched laugh*). Umm, you're in that pain, you have to live with it. Um, you know, so go do certain particular exercise and co... or they don't even tell you to come back.

(Margaret, patient participant)

The phrase 'you're a patient' was an important descriptor of the depersonalization that Margaret had experienced. Patients preferred the interaction experience to incorporate personal, friendly, and caring components in addition to the clinical and professional.

In a final example, patient Robyn suggested that it was possible for physiotherapists to be clinical or scientific in their manner as well as caring. For Robyn, feeling cared about was linked with the experience of being part of an equal relationship with the physiotherapist, rather than being looked down upon.

He's quite scientific and I probably like a scientific approach to it, but he's also quite caring – whereas I found some others patronizing.

(Robyn, patient participant)

The finding that patients appreciated feeling valued as part of a friendly relationship in which the physiotherapist provided them with a genuine sense of care has appeared infrequently in the literature. In interviews, Peiris and

colleagues (2012) asked rehabilitation inpatients what they valued about the physiotherapy experience, and patients described empathetic and caring physiotherapists as an important component. Patients in private practice also reported that they expected a friendly, polite, listening therapist who made them feel comfortable (Potter et al., 2003b). The outcomes of my study concur with these findings about patient values and expectations. Patients appreciate a caring, empathetic, friendly physiotherapist who actively listens and makes them feel comfortable.

Patients sought rapport with their physiotherapist

Patients reported seeking a connection or rapport during interactions with physiotherapists. Feeling comfortable and connected with their physiotherapists was important to patients. Patients described casual conversation, humour, physiotherapist self-disclosure, and 'two-way' communication as communicative elements that assisted to create the comfortable connected relationship that they desired. The following section details these communicative elements as outlined by patients during their interviews.

Patients identified the links between 'getting on' through casual conversation, feeling relaxed, and being more able to talk about the treatment aspects of their interaction.

Getting on with people, talking to people, getting on and just keeping the communication going, flowing, conversations, ah – like being able to talk about general things that are happening outside, outside work so to speak, not in just in the practice. I think that's very important.

(Simon, patient participant)

It's very relaxed. Yeah, because he has those people skills he puts me at ease, makes me relax. And that makes it very easy to talk about treatment.

(Simon, patient participant)

In addition to feeling at ease due to casual conversation, patients valued humour as part of a friendly relationship that made them feel comfortable. Patients Laura and Robert both explained feeling at ease with the friendly, jovial nature of their relationships with their physiotherapists.

She's a lovely person and I think her – you know, kind of, I guess we've just built up a bit of a relationship and she just jokes around.... I guess that does make me feel more comfortable to tell her how I really feel.

(Laura, patient participant)

With John it's more a friendly sort of thing. Like we joke sometimes and yeah.

(Robert, patient participant)

In addition to helping patients feel relaxed and comfortable, casual conversation was reported to build a connection between patients and physiotherapists. Having something in common, or finding something to bond with during conversation, was seen as a particularly important component of interactions between patients and physiotherapists. This bond established an underlying connection that supported the development of the patient-physiotherapist relationship.

The ideal relationship would have a good combination of both talking about the treatment and also the other aspects, the general outside world. It's mostly a professional relationship, I don't talk to him about his personal life and he doesn't ask me, generally asking about other things

besides the treatment, like I said about footy and yeah, sport – so that’s something that we have in common.

(Simon, patient participant)

Patients spoke of the importance of a bond during their interactions and explained that casual conversation and humour assisted to form this connection. Talking about things other than the physical injury or ailments was important to all patients. There were, however, a range of perspectives about the appropriate level of personal conversation. Patients wanted to feel comfortable to talk about more personal matters with physiotherapists. When asked whether he considered that the physiotherapist could understand more about social and emotional aspects of his life, patient Robert recalled that physiotherapist John understood those aspects and that he subsequently felt a connection with him. Robert explained that he felt less comfortable sharing with his current female physiotherapist.

Yeah, well John seems to understand all that. That’s why I’ve sort of made a bond with him. Being a woman I just thought I don’t wanna really talk about my personal problems but I felt more comfortable talking to John about it so, yeah.

(Robert, patient participant)

Patients regarded understanding the emotional and psychosocial components of each other’s lives as an important aspect of achieving rapport. As a component of this, patients suggested that physiotherapists who talked about aspects of their own life, and therefore related to the patient on a personal level, facilitated a degree of common experience between them that enhanced rapport.

I think it’s nice if you know the person and a bit about them. Because, I mean my podiatrist, I know a bit about her, we talk about her family and

her boyfriend and you know, where they go, all this sort of stuff. It just makes nice conversation and you feel that you've got a bit more in common with them.

(Jocelyn, patient participant)

Reiterating Jocelyn's opinion that physiotherapists should talk about themselves, patient Peter provided a detailed description about his perception that physiotherapists needed to self-disclose more about their feelings and experiences to create a genuine connection with patients.

Peter: I mean in terms of um, creating that, I guess that emotional link will mean probably that the physio is going to have to give a bit more of themselves perhaps, to get people to open up that way. People don't naturally talk about their feelings. It's easier when you're getting, you've got a problem with something and you can talk about how that feels. More not psychologically how you feel. You feel pretty crap and I don't know.

Amy (interviewer): So you're saying that you think that the physio needs to open up a bit more about themselves or be a little bit more open //in order to allow that to happen.

Peter: // YES... to create that.

Amy: So that's why you are saying//

Peter: //to build that. All I was thinking is to allow that, I know it's about the patient interaction but it'll need to be, I guess I'm thinking the physio will need to be a bit more giving to create that bridge. I mean you don't tell anyone something who just sits in and... but if they say, I had this experience and I feel so bad about it, I'd say 'oh yeah, me too' instantly you got, they've talked about their feelings.

(Peter, patient participant)

Peter spoke about creating an emotional connection and balancing the interaction. He suggested that incorporating both patients' and physiotherapists' opinions and perspectives would increase rapport between the two.

I reckon that'd be a great approach even in sessions with people, to just try and get their opinion rather than it being one-way, if you can make it two way, it would feel more balanced and, not that it needs to be, but it would help that connectivity I reckon.

(Peter, patient participant)

In this section I have shown that patients appreciated physiotherapists acknowledging psychosocial aspects of their lives. Patients sought to incorporate psychosocial discussion and understandings, but expressed the opinion that they felt more comfortable doing this when physiotherapists also disclosed psychosocial aspects of their own lives. Achieving this type of disclosure was believed to be an avenue to assist rapport.

Self-disclosure by physicians has been suggested as a means of building rapport with patients (Beach et al., 2004). The type of practitioner disclosure that patient Peter proposed commonly occurs in medical interactions and is termed reassurance: assuring patients that their experience is normal by comparing it to an experience of their own (Beach et al., 2004). Patient participants in my study explained that they sought this reassurance. Casual conversation in my observational data incorporated some occasions of physiotherapists disclosing their interests or opinions as a form of reassurance. Emotional experiences, however, were rarely disclosed by physiotherapists in the interactions I observed. An equal discussion in which both patients and physiotherapists disclosed their feelings might be a means of achieving reassurance and fostering rapport between the two.

An appreciation for the experience of being understood and related to as an individual, as described by patients in my research, resonates with results from a physiotherapy study undertaken in the United Kingdom (Cooper et al., 2008). In interviews, patients with lower back pain spoke about valuing individualized care and being treated as a 'person not a number' (Cooper et al., 2008, p. 248). In my study, patient participants requested similar individualization. I propose that this individualization was present because of the incorporation of adaptive communication. Cooper and colleagues (2008) also reported that their patient participants valued adjustments made by physiotherapists in response to patient feedback (Cooper et al., 2008). Here, I combine observational, patient, and physiotherapist perspectives, and conclude that physiotherapists were incorporating adaptations or adjustments as a complex response to individual patient characteristics. These adaptations ultimately resulted in personalized care.

Patient participants stated that characteristics such as being caring, friendly, and a good listener, were desirable in their physiotherapist. Such characteristics were also reported as qualities of a good physiotherapist in a study incorporating the perspective of the private practice physiotherapy patient (Potter et al., 2003c). In addition, these characteristics are described in discussions about interpersonal trust in the healthcare setting (Hupcey & Miller, 2006). These similarities provide good evidence that patients desire trust or trustworthy qualities in their interactions with physiotherapists in private practice.

Trust is considered a dynamic process that evolves with time (Dinc & Gastmans, 2012). Adaptations are therefore a possible means for the dynamics of trust to be achieved and maintained. Assisting in the development of a trusting relationship underscores the importance of adaptations occurring in patient-

physiotherapist interactions. The link between adaptive communication and the development of trust in the patient-physiotherapist interaction will be explored further in Chapter six.

To summarize, patient interview data corresponded with physiotherapist interview and observational data to demonstrate the centrality of adaptive communication occurring in patient-physiotherapist interactions. Patients provided insights into physiotherapist attributes, and into communicative elements that they considered formed adaptations. Patients also described these adaptive communicative elements as functioning to demonstrate genuine care and to facilitate rapport.

Summary of adapting to build rapport

Adaptive elements of communication present in all three data sources were eye contact, body language, touch, casual conversation, and humour. All data sources verified that the purpose of adaptive communication was to create a connection between patient and physiotherapist. Figure 9, in the introduction to Chapter five, illustrates that elements emerging from each of the three data sources aligned and overlapped, corroborating and giving strength to the findings of adaptive communication.

Adapting is acknowledged in the Code of Conduct written by the Physiotherapy Board of Australia. It states that good practice: ‘involves practitioners understanding that each patient or client is unique and working in partnership with patients or clients, adapting what they do to address the needs and reasonable expectations of each person’ (Physiotherapy Board of Australia, 2014, p. 7). The significance of my observations relating to the types of adaptive processes involved in dealing with each patient’s needs and expectations is

considerably enhanced by the fact that adaptation is deemed necessary by physiotherapy professional organizations. Moreover, although the Physiotherapy Board of Australia advocates adapting to the individual as an important component in physiotherapy practice, until now adapting has not been the focus of research exploring interactions with patients in physiotherapy.

Some findings from a recent study, however, resonate with my findings about adapting, particularly with regard to the specific dimension of touch. In Bjorbaekmo and Mengshoel's (2016) qualitative exploration of interactions in primary care clinics in Norway, touch emerged as being a medium through which understandings and responsive adjustments were made. A physiotherapist participant explained a responsive sense that he incorporated into his treatment. The authors wrote:

Talking about adapting treatment to the actual patient, [physiotherapist] John said:

'It is about response, response on what you are doing. . . There is a lot of unspoken. . . lots of unspoken information and responses that you capture. It's not passive massage, there are massage and movement, and if there is resistance I catch it at once. Then it does not help to fight against. . . – it is just hopeless. You must do things in a different way' (Bjorbaekmo & Mengshoel, 2016, pp. 15-16).

John the physiotherapist reported implementing touch as an element of adaptation similar to the reported findings about touch from my research. This empirical evidence increases the significance and relevance of adaptive communication in physiotherapy practice, further validating my findings.

To conclude, adaptive communication was an integral component of interaction in the data. My descriptions of elements of adaptive communication such as touch, body language, eye contact, casual conversation, and humour provide much-needed specific information about adaptive communication. These details, directly derived from physiotherapy practice, offer new insights for physiotherapy practice because they demonstrate how adaptive communication is implemented and the role it plays in patient-physiotherapist interactions. My findings effectively augment previous knowledge from normative and empirical literature to substantiate adaptive communication as an important part of physiotherapy practice that functions to develop rapport between patient and therapist.

In the final section of this chapter I consider how the findings presented in the themes 'physiotherapist-led communication' and 'adapting to build rapport' relate to established healthcare interaction approaches.

Comparing the research findings with approaches to healthcare interaction

The second aim of this research was to consider whether and how patient-physiotherapist interactions occurring in practice correlated with established healthcare interaction approaches. In Chapter two I outlined the practitioner-centred, biomedical, patient-centred and biopsychosocial approaches as established frameworks for healthcare interaction. The commonalities between practitioner-centred and biomedical, as well as patient-centred and biopsychosocial approaches, were detailed. I also explained that although each of these approaches was predominantly developed for the medical profession, they have been adopted in physiotherapy, and the physiotherapy profession strongly promotes biopsychosocial and patient-centred approaches. Moreover, I

highlighted that these approaches are not derived from empirical evidence and do not necessarily provide accurate theoretical representation of interaction in physiotherapy practice.

Furthermore, in Chapter two, I noted that a small body of physiotherapy interaction literature concludes that aspects of interactions in physiotherapy align most closely with biomedical and practitioner-centred approaches (Cruz et al., 2012; Josephson et al., 2015; Opsommer & Schoeb, 2014). These conclusions do not resonate with the patient-centred and biopsychosocial approaches endorsed by the physiotherapy profession. This potential theory-practice gap signifies the importance of examining the relevance of current theoretical approaches to practice. In this section, to achieve my second research aim, I advance the discussion by comparing the features of these approaches with the elements of interaction found in my research. I first compare my findings with biomedical and biopsychosocial approaches that focus on the content or topics of conversation in interactions. I then compare findings with the practitioner- and patient-centred approaches that describe processes of interacting with patients.

Comparison with biomedical and biopsychosocial approaches

In Chapter four, under the heading ‘physiotherapist-led communication’, I detailed a distinct focus on physical aspects and pain as an element of observed interactions. More specifically, biological aspects, such as the nature and location of pain and associated anatomy, were the predominant topics of conversation in observed patient-physiotherapist interactions. These findings correspond to a biomedical approach. Psychosocial content was occasionally incorporated as an adaptation from the dominant biological pattern, particularly during casual conversation. The previously stated conclusion that interactions in physiotherapy align closely with a biomedical approach (Cruz et al., 2012;

Josephson et al., 2015) is strengthened by my findings that the content of patient-physiotherapist interactions was predominantly biological.

Comparison with practitioner-centred and patient-centred approaches

Elements of communication in my theme 'physiotherapist-led communication' relate closely to the features of a practitioner-centred approach. Data from my research demonstrated that physiotherapists provided a consistent structure, initiated conversation and questions, asked closed-ended questions, made decisions, and focussed on physical aspects and pain. All these elements of communication in my findings directly correlate to features of a practitioner-centred approach.

In contrast, elements of my second theme 'adapting to build rapport' do not neatly align with features of established healthcare interaction approaches. Key elements of adaptive communication such as body language, eye contact, touch, casual conversation, and humour from my findings do not correspond to described features of established approaches to interaction. This may be because communicative elements of my theme 'adapting to build rapport' were mostly non-verbal, and the specifics of non-verbal communication are not detailed as part of established approaches to healthcare interaction.

Intuitively, it may seem that elements of adaptive communication presented in my research would relate more closely to features of patient-centred care. However, this is not the case. There is a fundamental difference between the purpose of communication in my theme 'adapting to build rapport' and the purposes or values of a patient-centred approach. The adaptive communication that I reported functioned to create a human connection and to support a harmonious patient-physiotherapist relationship. In contrast, a patient-centred

approach describes interactions that are collaborative and that incorporate the individual patient's needs and perspectives (Ellis, 1999; Mead & Bower, 2000; Smith et al., 2013). This fundamental difference, along with the prevalence of features of practitioner-centred communication evident in my study, leads me to conclude that my findings do not correlate neatly with a patient-centred approach to interaction. Neither do my data correlate entirely with a practitioner-centred approach, as this approach similarly does not incorporate findings presented in my theme 'adapting to build rapport'.

I conclude that there is a potential gap between the physiotherapy professions purported ideals of patient-centred, biopsychosocial approaches to interaction and the reality of interaction in private physiotherapy practice.

Summary

In this discussion section I have presented the results of my second research aim: to consider how my empirical findings related to established healthcare interaction approaches. I returned to the healthcare interactional approaches that are regarded as relevant to physiotherapy, and considered my findings in relation to each approach. My findings do not relate to core features of patient-centred or biopsychosocial approaches. Some of my findings, those from the theme 'physiotherapist-led communication', correlate to biomedical, practitioner-centred approaches. These approaches, however, do not incorporate elements of adaptive communication, human connection, and rapport that were strongly evident in the observed interactions. In addition, biomedical, practitioner-centred interaction styles are criticized for neglecting the human dimension of patients and dichotomizing body and mind (Borrell-Carrio et al., 2004; Engel, 1977). These approaches are therefore inadequate and

inappropriate representations of patient-physiotherapist interactions as they occur in private practice.

Good theories need to describe established patterns derived from empirical research (Van de Ven, 1989). Because the promoted approaches to interaction do not describe patterns of interaction derived from empirical research, I therefore conclude that the established and promoted approaches to interaction are not adequate as theories of interaction to support interactions occurring between patient and physiotherapist in private practice.

Hence, the aim of the following discussion chapter is to explore alternative frameworks that might explain my findings. To do this I combine the research findings that have been presented as two separate themes and explain how they complement each other. In the discussion in Chapter six I emphasize the relationship between patient and physiotherapist as central, and offer relationship-centred care as an alternative approach that integrates all elements of communication in my findings. In addition, to further elucidate the relationship between patient and physiotherapist, I relate my findings to concepts of power and trust. I advance my empirical findings in support of my claim that the combined frameworks of relationship-centred care and trust are relevant and applicable to interaction in physiotherapy private practice.

Chapter six: Theorizing the patient-physiotherapist interaction in private practice

Introduction

The two previous chapters presented results as elements of patient-physiotherapist interaction within two broad themes: 'physiotherapist-led communication' and 'adapting to build rapport'. Within these themes I provided detailed descriptions of communication between patients and physiotherapists. However, presenting findings as two separate themes artificially divided patient-physiotherapist interactions. In reality, there was integration between the two themes: adaptive communication occurred amid physiotherapist-led communication. Interaction was found to be a dynamic and relational process that shifted and changed in response to the characteristics and needs of both patient and physiotherapist. Furthermore, fundamental to the interaction was the development of a relationship between patient and physiotherapist characterized by rapport and supported by trust. In this chapter I discuss how physiotherapist-led and adaptive communication both assisted the development of a trusting relationship, thereby amalgamating the themes and concepts arising from my findings.

In Chapters four and five I discussed each discrete element of communication. In addition, at the end of Chapter five, I considered how the findings related to established approaches of healthcare interaction such as the biopsychosocial approach and patient-centred care. I concluded that approaches to interaction frequently described in the literature neither adequately explained nor reflected my findings. To elaborate, in my data there were elements of clinical communication, namely those within the theme 'physiotherapist-led communication', that corresponded to the features of a practitioner-centred

approach. However, elements of communication within the theme 'adapting to build rapport' did not clearly correlate with features of established interactional approaches. This discussion chapter therefore aims to theorize physiotherapy communication by identifying and analyzing other theoretical explanations that may account for my findings about interactions in physiotherapy private practice.

In this chapter I arrive at two conclusions. First, interactions between patients and physiotherapists in private practice are indicative of a relationship-centred approach. Second, trust is the foundation for the patient-physiotherapist relationship. This chapter is divided into two sections. In the first I describe relationship-centred care and explain how it provides a framework that encompasses my findings. In the second section, I further conceptualize the patient-physiotherapist interaction by exploring notions of trust and power that reinforce the dynamic, relational nature of patient-physiotherapist interactions. These explanations enrich understandings regarding the practice of interaction in the private physiotherapy setting.

Explaining the results: relationship-centred care

There are a number of possible theoretical explanations for the two themes that arose from my analysis. Most of these explanations separate into my two themes 'physiotherapist-led communication' and 'adapting to build rapport'. A relationship-centred approach, however, encompasses communicative elements from both themes and therefore provides a unifying framework incorporating all of the findings. In this section I first discuss the two themes as representative of two goals of patient-physiotherapist interactions and provide some possible theoretical explanations. I then centre on a relationship-centred approach that,

in contrast to other possible explanations, accounts for all communicative elements of patient-physiotherapist interaction.

‘Science’ and ‘art’: two components of practice

The practice of medicine in its broadest sense includes the whole relationship of the physician with his [sic] patient. It is an art, based to an increasing extent on the medical sciences, but comprising much that still remains outside the realm of any science (Peabody, 1927, p. 813).

As Peabody (1927) stated in his landmark article ‘The Care of the Patient’, the relationship between patient and practitioner is central to the practice of healthcare. Because the patient-practitioner relationship is a professional one with a required outcome, it usually incorporates clinical and technical tasks; these encompass Peabody’s ‘science’ of medicine. Equally, because it is a relationship between two humans, it frequently incorporates care and empathy: Peabody’s ‘art’ of medicine. Peabody’s (1927) definition implies that in medical practice both art and science are integrated. Here, I propose that physiotherapy interactions in private practice include two similar inherent goals: to provide clinical treatment as the clinical, therapeutic or functional goal, and to care for the patient as the human, caring, empathic goal. My two themes correlate closely to these goals. Although there is some overlap, physiotherapist-led communication is the expression of the goal to provide clinical treatment, and adapting to build rapport is the communicative manifestation of the goal to care for the patient.

Many of the communicative elements presented in Chapters four and five support my claim for these two goals of interaction. For example, physiotherapists focussing on physical aspects and pain during their communication with patients encapsulate the clinical goal to maximize the

patient's movement potential. To achieve this goal, physiotherapists structured their interactions, initiated questions, and made decisions that assisted their clinical reasoning processes and assessment and treatment procedures. In addition, the use of adaptive communication such as touch, body language, and eye contact were responsive to the individual patient's needs and demonstrative of the goal to care for the patient as an individual.

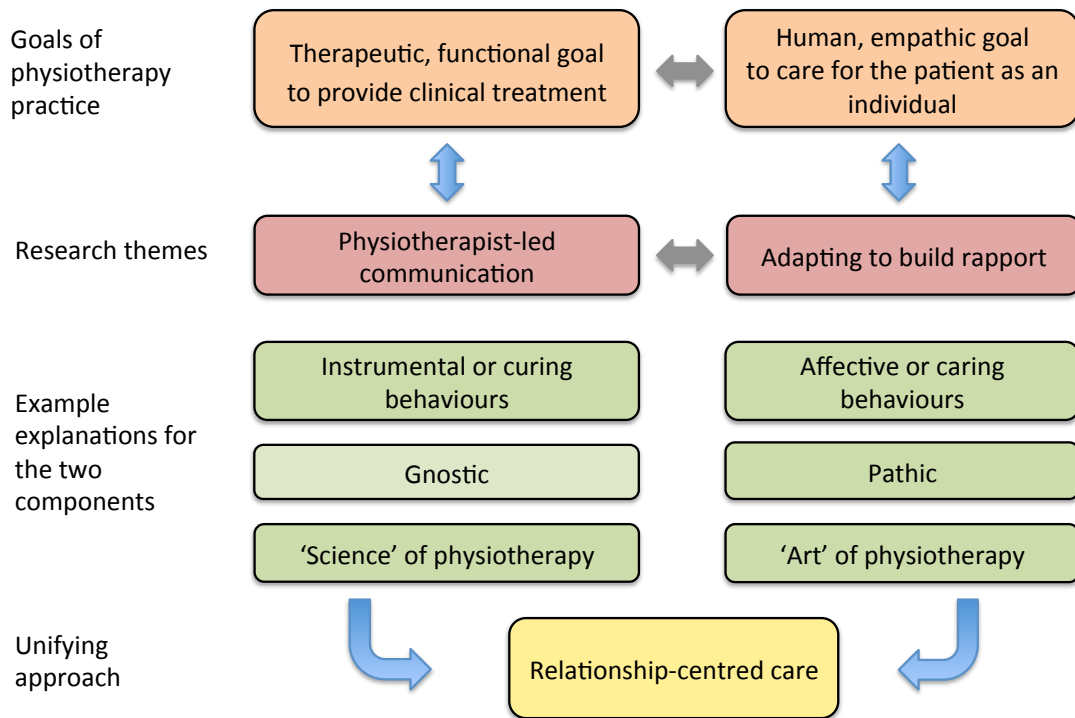
The clinical goal to provide assessment and treatment and the human goal to provide care for the individual patient have been acknowledged as important for physiotherapists when interacting with patients. The WCPT's 'Policy statement: Description of physical therapy' (2011), defines physical therapy as a health profession concerned with 'identifying and maximising quality of life and movement potential' (p.1), and explains that the scope of practice is to be 'dynamic and responsive' (p.1) to patient needs. These two statements confirm that at an international policy level, the profession acknowledges the importance of both clinical and human goals. Similarly, physiotherapy literature also outlines clinical goals to enable optimal physical function for individuals (Gibson & Martin, 2003; Higgs et al., 2001), and human goals to focus on caring for the individual (Plack, 2005). Furthermore, Tasker and colleagues (2011) referred to both the 'therapeutic dimensions of care' (p. 178) and 'the human and social elements of care' (p. 178). By representing these two goals, my findings provide evidential support that strengthen and verify the acknowledgement of these two goals of physiotherapy evident in policy statements and professional literature.

There are numerous references to these two goals of practice in the healthcare and health sociology literature. Many of these references suggest that integration between the clinical and the caring goals is required in the patient-practitioner interaction. Peabody's (1927) notions of 'science' and 'art' are reiterated by Ong and colleagues (1995) who referred to communicative behaviours being

oriented towards either instrumental or curing goals, or affective or caring goals. Equally, van Manen (2014) explained gnostic and pathic components as important to practice. The gnostic component is the scientific process associated with features such as diagnosis and prognosis, and pathic understandings are those that incorporate affect and emotions such as empathy and sympathy.

These concepts present as possible theoretical explanations for the two goals of interaction in physiotherapy private practice. Each explanation, however, includes two separate descriptors. In contrast, a relationship-centred approach is a convincing alternative framework because it encompasses both goals of interaction in a single concept. A relationship-centred approach incorporates the two themes, and accounts for all communicative elements of patient-physiotherapist interaction found in my research. Figure 11 is a representation of the inter-related concepts and possible explanatory theories described in this section.

Figure 11: The associations between findings and conceptual explanations



In Figure 11 the research themes are central and are coloured red. I have connected the two themes to the corresponding goals (orange) of physiotherapy practice. The grey arrows represent the integration between the two themes and the two goals, signifying that there is clinical value in the human goal and, furthermore, that clinical goals can be considered caring. Below the themes, and in green, are examples of explanations for the two themes described as research findings. Relationship-centred care (yellow) is presented at the bottom as a unifying approach that connects the two themes and goals.

There are three principal reasons why I propose a relationship-centred approach as an appropriate framework for patient-physiotherapist interactions in the private practice setting. First, it was apparent from my findings that a

relationship based on trust between patient and physiotherapist was fundamental to the patient-physiotherapist interaction. Second, the relationship was reported to be of central importance by both patient and physiotherapist participants. In their interviews, patients spoke about their desire to feel connected to their physiotherapist. Physiotherapists also explained that they sought a personal component to their relationship with their patients. Finally, as stated earlier, a relationship-centred approach unifies the two central themes and all elements of communication from my findings.

Relationships and relationship-centred care as an interactional approach

A relationship is neither a 'thing', nor a 'function', but rather an 'abstraction embodying the activities of two interacting systems (persons)' (Szasz & Hollender, 1956, p. 586). A relationship therefore centres on the connections between two persons as they interact with each other. In the healthcare setting, the patient-practitioner relationship is often termed the therapeutic relationship or therapeutic alliance (Bachelor & Horvath, 1999; Cole & McLean, 2003; Ferreira et al., 2013). Such relationships have been reported to be important to both patients and practitioners (Roter & Hall, 2006). In healthcare literature, characteristics such as: collaboration, communication, empathy, understanding, connection, and to a lesser extent, trust have been described as parts of the therapeutic relationship (Cole & McLean, 2003). From their research surveys, Cole and McLean (2003) formulated a definition for the therapeutic relationship based upon the perspective of occupational therapists: 'a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual respect' (Cole & McLean, 2003, p. 49). This definition assists to delineate the features of a successful therapeutic relationship and encompasses many of my findings.

Over time, the relationship between patient and practitioner has been described and defined by a number of authors. Szasz and Hollender (1956) presented models of the doctor-patient relationship, portraying the construct of mutual participation, and emphasizing that a human relationship embodies the activities undertaken between two interacting persons. Later, Emanuel and Emanuel (1992) added consideration for ethics, and patient and physician values to their outlines of four different styles of physician-patient relationship. Tresolini and the Pew-Fetzer Task Force (1994) sought to develop strategies to overcome barriers to the integration of biomedical and psychosocial issues within healthcare and education. They recognized the patient-practitioner relationship as therapeutic in itself and the foundation for care, and used the phrase 'relationship-centred care' to formally acknowledge the centrality of relationships (Tresolini & The Pew-Fetzer Task Force, 1994). As is the case with my findings, their descriptions incorporate both biomedical and human elements such as caring into healthcare interactions.

Notions of relationship-centred care have since been further theorized and incorporated into healthcare literature (Beach & Inui, 2006; Bylund et al., 2012; Oprea, 2009; Roter, 2000). Roter (2000) explains relationship-centred care as incorporating five characteristics expressed through communication. Beach and Inui (2006) extended perspectives about relationship-centred care by emphasizing the importance of authenticity and emotions, and promoting relationship-centred care as a broader framework for conceptualizing healthcare. In addition, ethical perspectives of a relationship-centred approach were considered by Oprea (2009). Many of these descriptions of relationship-centred care are considered approaches to patient-practitioner interaction.

Although I recognize the value of these different descriptions of relationship-centred care, I refer to the relationship-centred approach explained by Roter

(2000) because it incorporates all the elements of communication in my two themes. In particular, Roter's relationship-centred care acknowledges and integrates functional characteristics as essential attributes of healthcare professional relationships. Functional characteristics are the healthcare management functions and technical tasks that need to be accomplished as part of the patient-practitioner relationship (Roter, 2000). They correspond to the clinical, technical elements of patient-physiotherapist interactions derived from my data. Furthermore, Roter's description advocates that the patient-physician relationship is expressed through communication, and centres on communicative processes indicative of the relationship. My research exploring interactions in physiotherapy primarily studied communication; therefore Roter's approach provides an appropriate description specifically pertaining to the type of data I have collected.

Roter (2000) specifies that an interaction epitomizing her 'relationship-centred care' incorporates five characteristics of a patient-practitioner relationship. The relationship must be 'medically functional, informative, facilitative, responsive and participatory' (Roter, 2000, p. 8). I next detail these relationship-centred characteristics, discussing how my findings relate to them. Specifically, I detail how the functional, informative, and responsive characteristics are strongly evident in my results. I also explain that the facilitative and participatory characteristics of Roter's (2000) relationship-centred care were less apparent in my findings and discuss how these characteristics might need to be framed differently in a private physiotherapy context to account for the specifics of private physiotherapy practice.

Table 3 lists the characteristics of relationship-centred care and summarizes how elements of communication from my research results relate to each of the characteristics.

Table 3: Elements of communication in patient-physiotherapist interactions related to characteristics of relationship-centred care

Characteristics of relationship-centered care (D. Roter, 2000)	Elements of communication from my research
<ul style="list-style-type: none"> • Medically functional (Incorporating management and technical tasks that are required as part of healthcare treatment) 	<ul style="list-style-type: none"> • Physiotherapist-led communication <ul style="list-style-type: none"> - Structured interaction incorporating technical tasks of assessment and treatment - Biomedical content
<ul style="list-style-type: none"> • Informative (Providing technical information and behavioural recommendations in a motivating, useful manner) 	<ul style="list-style-type: none"> • Physiotherapist-led communication <ul style="list-style-type: none"> - Biomedical information conveyed as content - Directive style used
<ul style="list-style-type: none"> • Responsive (Providing support, empathy, concern, and legitimation of the patient's emotional state) 	<ul style="list-style-type: none"> • Adapting to build rapport <ul style="list-style-type: none"> - Touch - Casual conversation - Humour - Eye contact - Body language
<ul style="list-style-type: none"> • Facilitative (Eliciting the patient's story and experiences) 	<ul style="list-style-type: none"> • Adapting to build rapport <ul style="list-style-type: none"> - Adaptive communication facilitated patient comfort • <i>Verbal components of facilitation were lacking</i> • <i>Technical touch was used to facilitate patient involvement in movement and exercise</i>
<ul style="list-style-type: none"> • Participatory (Helping patients to participate in dialogue and decision making) 	<ul style="list-style-type: none"> • <i>Verbal components of participation were lacking</i> • <i>Patients actively participated in movements and exercises</i>

Table 3 demonstrates that elements of communication derived from my data analysis largely correspond to the characteristics or components of relationship-centred care. My theme 'physiotherapist-led communication' incorporates communicative elements of interaction in physiotherapy that match the functional and informative characteristics of a relationship-centred approach. Elements of communication reported in my theme 'adapting to build rapport' also clearly correspond to the implementation of responsive and, to a lesser extent, facilitative components of relationship-centred care. The participation characteristic was less evident in my patient-physiotherapist interactions.

The first characteristic of relationship-centred care as described by Roter (2000) is that the central purpose of the relationship between patient and practitioner is to achieve a functional outcome. The inclusion of a functional characteristic is a strength of this approach because it acknowledges that healthcare relationships are professional relationships with specific goals and clinical tasks to achieve in order to provide quality care. The functional characteristic increases the applicability of relationship-centred care to healthcare practice. Responsibilities such as structuring the visit, being efficient with time management, and performing technical tasks are listed as examples of functional characteristics of relationships under a relationship-centred approach (Roter, 2000). These responsibilities are important features of healthcare practice, and recognition of the need to incorporate these acknowledges that the patient-practitioner relationship has a specific and professional purpose. Roter (2000) terms these the 'medically functional' aspects of the interaction.

Elements of my research theme 'physiotherapist-led communication' clearly relate to the functional characteristic of relationship-centred care described by Roter (2000). Structuring the interaction in a manner that incorporated technical tasks, such as physical assessment and treatment, is a clear example. Equally, a

focus on pain and physical aspects was a required functional element of the interaction incorporated into the patient-physiotherapist relationship. These physical, biomedical components are necessary because the goal of physiotherapy treatment is to optimize physical function (WCPT, 2011). Roter (2000) explains that if the patient-practitioner relationship does not incorporate a functional characteristic it will fail both patients and practitioners by not allowing the accomplishment of basic healthcare tasks. My results substantiate this need for clinical, technical components to be incorporated into patient-physiotherapist relationships.

Physiotherapists spoke about functional tasks in their interviews, and this was recorded as a clinical or scientific purpose in the second section of Chapter four. Moreover, patient participants stated that they valued the direction and structure that physiotherapists provided. Patients expected physiotherapists to lead them through a clinical assessment and treatment process. The findings from my interviews suggest that both physiotherapists and patients perceived functional aspects to be essential, and demonstrate that a functional characteristic in the relationship is vital in physiotherapy private practice. The private nature of the setting may heighten the importance of the functional, task oriented components of patient-physiotherapist interactions.

Being informative is a second central characteristic of Roter's relationship-centred care (Roter, 2000). This characteristic means that the relationship must provide technical information, expertise, and behavioural recommendations (Roter, 2000). Medical and physiotherapy research confirms that patients consistently require information and education from healthcare practitioners (Cooper et al., 2008; Potter et al., 2003b; Roter, 2000). This 'information giving' varies between biomedical and psychosocial content, and between directive and suggestive styles (Hall, Roter, & Katz, 1988). Observational data presented in this

thesis highlighted information giving as part of the 'treatment and education' phase of the structured physiotherapy interaction. Physiotherapists informed patients about biomedical content such as anatomy, posture, and exercises, and used a directive style of educating. These elements were presented in Chapter four as part of physiotherapist-led communication. In addition, physiotherapists claimed that providing education and performing an educative role was part of their purpose during interactions with patients. Patients also explained in interviews that they valued physiotherapists' displays of clinical competence, specifically including physiotherapists' ability to provide them with knowledge and information. These examples and explanations of clinical and behavioural knowledge imparted by physiotherapists fit Roter's description of the informative characteristic of relationship-centred care.

My results demonstrated that patient-physiotherapist relationships were informative in so far as they incorporated information exchange. This information exchange was, however, generally limited to biomedical content presented in a directive manner. Roter (2000) further stipulated that to be informative, healthcare relationships need to convey applicable information in a comprehensible and motivating manner. My patient interview data indicated that although patients appreciated the technical terminology and the physiotherapist competence it conveyed, patients did not always understand the technical information that physiotherapists were providing. I therefore suggest that while patient-physiotherapist relationships were informative, there is some need for improvement in the manner in which the information is conveyed. This is a potential avenue for future research.

Third, a responsive component is recommended to be part of a relationship-centred approach. To be relationship-centred, healthcare practitioners are enjoined to respond to the patient's emotions and concerns in a manner that

conveys empathy (Roter, 2000). This responsiveness is described elsewhere as central to building rapport and to allowing patients to feel cared for and understood (Cole & McLean, 2003; Tasker, Loftus, & Higgs, 2012).

Responsiveness corresponds to the adaptive communication that I reported in Chapter five. By definition, adapting is responding, and through adaptive communication the physiotherapists in my study responded to the emotions and concerns of their patients. The implementation of elements of adaptive communication such as touch, body language, eye contact, casual conversation, and humour are evidence that responsiveness was a characteristic of the patient-physiotherapist relationship. In addition, to further support my statement that physiotherapists are responsive in their relationships with patients, both patients and physiotherapists recognized that adaptations were occurring and that these responses were central to building rapport. The characteristic of responding was therefore clearly apparent in the patient-physiotherapist relationship.

A fourth key characteristic of relationship-centred care is facilitation: healthcare practitioners are required to assist patients to express their story, incorporating the agenda for their visit and their experience of their concerns (Roter, 2000). The patients' role here is to tell their story, and psychosocial components are particularly relevant. During my interviews, as outlined in Chapter four, patient participants concurred, stating that their role was to provide the physiotherapist with information. In Chapter five I explained that physiotherapists wanted to understand and elicit the patient's story, suggesting that they intended to be facilitative. During observations, however, facilitation to assist patients to tell their story was lacking: adaptive communication was responsive and incorporated empathy, but did not function to ascertain the patient's perspective.

It appears that although patients and physiotherapists both intended their relationship to have a facilitative characteristic, in practice this aspect was limited. It could be argued that the observed adaptive communication facilitated patients to be sufficiently comfortable to convey their experiences. However, specific verbal language to elicit the patient perspective was not a feature of patient-physiotherapist interactions. In fact, at times, direct communication by physiotherapists, such as interrupting and closed-ended questioning, was likely to disempower patients to express their story. Facilitating patients to engage and tell their story in physiotherapy interactions is therefore a potential avenue for improvement and warrants further research; it also has implications for physiotherapy education.

A further consideration is that the facilitative characteristic of relationship-centred care may require a different definition in physiotherapy. Facilitation is considered to be a way in which physiotherapists assist patients to perform movements (Armutlu & Fil, 2010; Beeston & Simons, 1996; Kawahira, Shimodozono, Ogata, & Tanaka, 2004; Westwater-Wood, Adams, & Kerry, 2010). That is, physiotherapists facilitate patient movement and function through physical handling or manual guidance (Beeston & Simons, 1996; Talvitie, 1996). Physiotherapists view facilitation as an active process that encourages patient engagement and enables patients to take ownership of their own management through exercise and movement (Beeston & Simons, 1996). In this research I observed physiotherapists using technical touch as a powerful facilitator of movement both during mobilizing treatments and through exercises. Through this facilitation patients were able to 'feel' movements that assisted their engagement in exercise and promoted their ownership of home management. In summary, while facilitatory components that reflect Roter's (2000) definition of facilitation in relationship-centred care were not incorporated into patient-physiotherapist interactions in private practice, physiotherapists were

facilitating patient involvement non-verbally through movement and exercise using technical touch.

The final characteristic of the relationship-centred interaction is participation (Roter, 2000). To be relationship-centred, Roter (2000) states that practitioners have a responsibility to assist patients to participate in dialogue and decision making. Elements of patient-physiotherapist interactions in my research findings demonstrated that patients were generally not involved in decision making and that the patient role in dialogue was frequently limited to answering physiotherapists' questions. These physiotherapist-led elements potentially limited patient participation in the interactions.

Other authors have also observed that patients were minimally involved in decision making and goal setting processes in physiotherapy settings (Parry, 2004; Wohlin Wottrich et al., 2004). Research has highlighted the complexities and interactional challenges, particularly time delays, associated with physiotherapists' attempts to increase patient involvement in goal setting (Parry, 2004; Schoeb, 2009). Patient participation is a notable exclusion in the patient-physiotherapist relationship; this is of particular concern given that physiotherapy is a profession that requires active involvement from patients (Beeston & Simons, 1996; Poulis, 2007b; Schoeb & Burge, 2012). As I explained in Chapter two, patient participation is a defining feature of interactions in physiotherapy. Findings regarding patient participation in dialogue and decision making suggest that there is currently a gap between theory and practice. It is likely that, despite the challenges involved in patient participation, a greater participatory role in dialogue and shared decision making during interactions would assist the achievement of the goals and outcomes of physiotherapy practice.

I contend, however, that Roter's (2000) description of participation involving dialogue and decision making does not incorporate all aspects of patient participation evident in patient-physiotherapist relationships. As Schoeb and Burge (2012) describe, patient participation in the physiotherapy setting also includes exercise training. With regard to patient participation, patient-physiotherapist relationships are different from doctor-patient relationships in that they require commitment and active participation from the patient (Poulis, 2007b). Patients are required to engage in movement and exercise both during and between interactions with their physiotherapist. In the private practice context, this need for participation is potentially heightened because patients are self-funded and often have financial limitations on the number of treatment sessions they can attend.

During my research, patients were observed to partake in active therapy involving movement and exercises during interactions with physiotherapists. Patients listened intently, concentrated, and practised movements and exercises, demonstrating participation and engagement. Many aspects of the performance of these movements and exercises were collaborative and could be considered representative of a partnership. Developing this type of collaboration and mutual partnership between patient and practitioner is an important part of relationship-centred care (Roter, 2000). Thus, I suggest that although the physiotherapy profession may need to consider ways to adopt a collaborative, shared decision making approach, the description for participation in relationship-centred care in physiotherapy, particularly in private practice, needs to be extended to incorporate participation in movement and exercises. Indeed, Roter (2000) describes a teaching element of relationship-centred interactions whereby practitioners equip patients with skills to help themselves, which is the essence of patient participation in exercises in physiotherapy.

In this section I have considered how elements of patient-physiotherapist interaction relate to Roter's description of relationship-centred care. I conclude that, unlike patient-centred care and the biopsychosocial approach, this theory explains and incorporates all communicative elements described in my findings. Based upon my findings, however, the facilitative and participatory characteristics of relationship-centred care require further consideration. That is, either a different description incorporating facilitation and participation in movement and exercises, or additional research and education to implement Roter's (2000) described features of facilitation and participation are needed.

A further limitation of Roter's (2000) relationship-centred care is that it does not provide detail about the patient's role in the relationship. How the patient contributes to the relationship would therefore benefit from further research. Relationship-centred care as detailed here, however, does provide an approach that: is relevant to the practice of interaction in physiotherapy, incorporates suggestions about aspects of the relationship that require further consideration, and elucidates specifics of the patient-physiotherapist relationship, particularly in the private practice setting.

My discussion now moves to consider how the communicative aspects of the patient-practitioner relationship and a relationship-centred approach have previously been applied to physiotherapy. In this discussion I highlight how my findings contribute to knowledge about relationship-centred care in physiotherapy.

Relationship-centred care in physiotherapy

Relationship-centred care is not an established approach for interaction in the physiotherapy profession, and rarely appears in the literature. In this part of my

discussion I review what is known about relationships between patients and physiotherapists, and consider Tasker and colleagues' (2012) perspectives about relationship-centred care as a potential approach to interacting in physiotherapy. In the course of the discussion I provide suggestions about the benefits of a relationship-centred approach to physiotherapy theory and practice.

My results establish the significance of the patient-physiotherapist relationship. Notably, rapport, which I defined as a harmonious relationship, was underscored as an important feature of the patient-physiotherapist interaction. Elements of communication presented in the theme 'adapting to build rapport', particularly those derived from patient and physiotherapist interview data, support the development of rapport and highlight the relationship as central. Furthermore, exploring Roter's (2000) relationship-centred care in relation to my findings confirmed that elements of the theme 'physiotherapist-led communication' also contribute to the professional relationship between patient and physiotherapist.

The importance of rapport and the therapeutic relationship or therapeutic alliance in physiotherapy is well established in both academic and normative literature (Hall et al., 2010; Harman et al., 2014; Health & Care Professions Council, 2013; Klaber Moffett & Richardson, 1997; Miciak, Gross, & Joyce, 2012; Physiotherapy Board of Australia, 2014; Pinto et al., 2012). Normative literature, including professional standards of conduct, claims that physiotherapists should 'understand the need to build and sustain professional relationships' (Health & Care Professions Council, 2013, p. 10) and 'recognize that relationships with service users should be based on mutual respect and trust' (Health & Care Professions Council, 2013, p. 7). Listening actively, and achieving engagement, trust, agreement, communicative success, and rapport are documented requirements of the therapeutic relationship (Miciak et al., 2012; Pinto et al.,

2012). Physiotherapy researchers have also explored the role of the therapeutic relationship or alliance impacting upon patient satisfaction and treatment outcomes (Hall et al., 2010; Klaber Moffett & Richardson, 1997).

My study contributes to this literature by providing some necessary empirical findings that confirm the importance of the therapeutic relationship in physiotherapy private practice. While requirements and outcomes of the therapeutic relationship are reported in the literature, specific communicative elements and descriptions of how they are incorporated and adapted to achieve the requirements of the therapeutic relationship in physiotherapy have not previously been detailed. Indeed, over a decade ago, Cole and McLean (2003) acknowledged the paucity of research into the specific features of therapeutic relationships in occupational therapy and physiotherapy. Elements of communication reported in this thesis contribute significantly to understandings about how physiotherapeutic relationships are developed in practice.

Although the relationship between patient and physiotherapist is frequently acknowledged, relationship-centred care as an approach to practice rarely features in physiotherapy literature. Tasker and colleagues (2012) discussed relationship-centred care being enacted in the community-based setting where physiotherapists visit patients' homes. Results from interviews in the community setting with physiotherapists, patients, care-givers, and family emphasized the human and evolving nature of relationships (Tasker et al., 2011, 2012). Correlating directly with the findings presented here, developing an emotional connection and feeling cared for as a person were important to patients and care-givers, and were described as significant in achieving and sustaining trust within relationships (Tasker et al., 2012).

My research extends Tasker and colleagues' (2011, 2012) discussion about the importance of relationships that are responsive, evolve, incorporate care, and are sustained by trust in the physiotherapy context in two ways. First, my findings have demonstrated that these ideals extend into the private practice setting. Similar to the community-based setting, the private practice setting may be another work context that enhances the significance of the relationship between patient and physiotherapist. Relationships in the private practice physiotherapy setting often involve numerous consultations over a prolonged period (Poulis, 2007b). Private physiotherapy practice also relies on patients to be actively involved in their treatment regime through the performance of home exercises (Poulis, 2007a). These features accentuate the need for an appropriate relationship that is functional, responsive, facilitatory, participatory, and informative. I add private practice as another physiotherapy setting that could benefit from a relationship-centred approach as a framework for practice.

The second way that my research has added to the findings provided by Tasker and colleagues (2011, 2012) is by further elucidating many elements of communication that contribute to the development of the relationship. Casual conversation and active listening have been described as ways to link the personal, social, and professional aspects of the relationship (Tasker et al., 2011). My research has added evidence for the value of casual conversation in the physiotherapy setting, particularly casual conversation that is social and human, and involves the physiotherapist as a willing and contributing participant. Furthermore, the use of humour, touch, body language, and eye contact have been described in some detail in this thesis to enrich understandings about the types of communication that are responsive and assist to develop trusting relationships with patients.

In summary, in this section I have described how a relationship-centred approach resonates closely with empirically derived elements of patient-physiotherapist interactions identified in this research. I have demonstrated that the patient-physiotherapist relationship is central to the interaction between patient and physiotherapist, and have used my findings to justify my proposal that a relationship-centred approach is appropriate for physiotherapy practice. In the second section of this chapter, I explore inherent notions of trust and power to further contextualize the relationship between patient and physiotherapist.

Elaborating on the relationship in the patient-physiotherapist interaction

In the previous section I referred to Roter's (2000) descriptions of relationship-centred care as an approach to patient-physiotherapist interaction that centres on communicative characteristics of the relationship. Surrounding these communicative characteristics, however, are sociological constructs of trust and power that support and sustain the relationship. These constructs are not part of Roter's (2000) descriptions of relationship-centred care. However, I argue that theories of trust and power need to be considered here in order to provide a comprehensive picture of the nuances within patient-physiotherapist relationships in private physiotherapy practice. In this section, I therefore incorporate these constructs to extend knowledge about the patient-physiotherapist relationship. In particular, I establish trust as the defining and sustaining feature of the relationship.

Power in the patient-physiotherapist relationship

Power has been defined as the potential to exert influence (Drinka & Ray, 1987), and 'a relative, potentially shifting control of resources' (Wentworth, 1980, p. 114). Power is inherent in all interpersonal relations including healthcare interactions (Nimmon & Stenfors-Hayes, 2016). The Code of Conduct provided by the Physiotherapy Board of Australia (2014) states that 'there is a power imbalance in the practitioner-patient/client relationship' and establishes that physiotherapists should not 'exploit patients or clients physically, emotionally, sexually, or financially' (p. 10). The type of power imbalance that the Physiotherapy Board of Australia recognizes, where the patient is considered vulnerable, is widely acknowledged in healthcare interaction literature incorporating many professions, including physiotherapy (Ainsworth-Vaughn, 1995; Harrison & Williams, 2000; Mead & Bower, 2000; Talvitie & Reunanen, 2002). The described imbalance assumes that a power asymmetry is brought to the interaction by the nature of qualifications, professional registration, and societal expectations of healthcare professionals such as physiotherapists (Swinglehurst, 2014). I argue, as have others, that power is also brought about by interactional processes (Maynard, 1991; Swinglehurst, 2014). In this section I describe communicative elements and other features of the process of private physiotherapy interaction that can impact upon power between patient and physiotherapist.

Many communicative elements in my findings indicated the power and influence of physiotherapists. These elements were incorporated into the theme 'physiotherapist-led communication' and include: the structured interaction, incorporation of biomedical content, physiotherapists interrupting patients, and physiotherapists making decisions. These elements or features of interactions have been seen to be indicative of practitioners exerting influence over patients

(Ainsworth-Vaughn, 1995; Hyden & Mishler, 1999). This picture of power in patient-physiotherapist interactions is, however, incomplete, and it is simplistic to not consider other means of exerting influence beyond the observable communicative elements.

Patients, as consumers in the private practice setting, also hold power because they have the potential to control negotiations (Reeder, 1972). This power involves patient choice, where patients as consumers are able to choose how to maximize the value of healthcare services and use resources to their best advantage (Fine, 1995; Laugharne & Priebe, 2006; Lupton, 2002). Supported by ethical concepts of autonomy and informed consent, patients have the choice to accept or refuse treatment (Laugharne & Priebe, 2006). Moreover, as consumers in the private practice setting, patients have the choice to attend or not attend appointments, giving them considerable power in their interactions with physiotherapists. This patient choice means that the authority of healthcare professionals is being increasingly challenged in modern healthcare (Haug & Lavin, 1979).

Although my observational findings revealed that patients tended to be recipients of the physiotherapist-led communication and decision making, in interviews patients explained that if they were not happy with the care provided they would not return for further treatment. This has previously been described as a power strategy termed 'exiting' (Asbring & Narvanen, 2004). Therefore, despite communicative elements that suggested that physiotherapists had power, patients have considerable choice and the potential to exert influence as consumers of the private physiotherapy 'product'.

Consequently, I suggest that patient-physiotherapist interactions incorporate power that is relational as both parties have the resources and potential to exert

influence. Although physiotherapists controlled and dictated many elements of communication, as consumers with choice, patients controlled other factors such as the initiation and conclusion of the relationship. In addition, adaptive communication was often used to adjust the power dynamic as the responsibilities and requirements changed throughout the interaction. In general, adaptive communication mediated the power of the physiotherapist established through direct, physiotherapist-led elements of communication by adding a caring, empathic element. More specifically, patients' use of adaptive communication, particularly humour, implicitly indicated an influence over the physiotherapist, thereby demonstrating another way in which adaptive communication adjusted the power dynamic. These factors combined to bring about a moment-by-moment interplay of power between patient and physiotherapist that was dynamic and changing.

Next, I consider the relational aspects of trust essential to the patient-physiotherapist interaction.

Trust in the patient-physiotherapist relationship

Roter (2000) stated that the patient-practitioner relationship is expressed through medical dialogue or communication. Her relationship-centred approach focuses on these communicative aspects of the relationship. Based upon my findings, I suggest that trust is an implicit construct that is the foundation for relationship-centred care. That is, relationship-centred care relies upon an assumption that trust is present in the interaction. While power is relevant to, and inherent within, the patient-physiotherapist relationship, it is trust that is the sustaining feature. Trust was fundamental to my research participants, particularly patients who spoke about trusting physiotherapists because they had confidence in physiotherapists' expertise and believed that physiotherapists

demonstrated genuine care for them as individuals. Moreover, building trust through communication, including casual conversation, is described among the findings of Tasker and colleagues (2011; 2012) who argue for the importance of relationships in the community physiotherapy setting. In this section I describe and define trust in the context of the patient-practitioner relationship, and then explain how and why patients and physiotherapists were trusting of each other and therefore developed a trusting relationship.

Trust is central to patient-practitioner relationships (Hall, Dugan, Zheng, & Mishra, 2001; Peabody, 1927; Pellegrino, Veatch, & Langan, 1991; Thom, Hall, & Pawlson, 2004). This centrality is confirmed by the extent of literature claiming that trust is essential and also describing the dysfunction that occurs when trust is violated (for example, Beiting et al., 2014; Belcher & Jones, 2009; Cole & McLean, 2003; Dinc & Gastmans, 2013; Eriksson & Nilsson, 2008; Hall et al., 2001; Potter, 1996). Here I consider the role of trust in the patient-physiotherapist interaction, and refer to literature that details types of trust in healthcare interpersonal relationships. I suggest that optimizing trust is a further requirement and characteristic of the relationship-centred physiotherapy interaction.

Although trust has received minimal explicit attention in physiotherapy research, it is presented in the normative literature as a fundamental component of patient-physiotherapist relationships. The 'Code of Conduct' for physiotherapy in Australia brings together many key concepts that accord with my findings. For example, the Code states that: 'relationships based on respect, trust and good communication will enable practitioners to work in partnership with patients or clients' (Physiotherapy Board of Australia, 2014, p. 9). In addition, 'The Standards of Proficiency' for Physiotherapists in the United Kingdom state that physiotherapists must: 'recognize that relationships with service users should be

based on mutual respect and trust' (Health & Care Professions Council, 2013, p. 7). As well as reinforcing the importance of the relationship between physiotherapists and their patients (service users), this description introduces the idea of mutuality and reciprocity. Codes of conduct certainly imply that physiotherapists have a fiduciary obligation to their patients.

Due to its complexities, there is no single definition of trust. In keeping with my notion of adapting, I refer to Baier's (1986) description of 'trust' as a verb and 'trusting' as an action. I consider that in the physiotherapy context, trust and trusting are constantly adapting and changing as the communication and relationship between patient and physiotherapist evolve. I also refer to Hardin's (1993) definition that trust has three components: 'A trusts B to do Y' (Hardin, 1993, p. 506). Hardin's definition confirms that trust does not have to be reciprocal. Indeed, in the healthcare literature, trust is primarily considered as the patient trusting practitioners to meet their responsibilities and treat them appropriately (Mechanic, 1998; Rolfe, Cash-Gibson, Car, Sheikh, & McKinstry, 2014).

In the private practice physiotherapy setting, however, trust is both reciprocal and relational. Patients trust physiotherapists to provide appropriate treatment and physiotherapists also need to trust that patients are willing to honestly impart the required information in order for physiotherapists to complete their assessment and treatment. In addition, physiotherapists trust patients to perform exercises at home and to return for follow-up treatment. These could be deemed the patient's role and commitment in the patient-physiotherapist interaction, and indeed were stated as such by patient participants in the research interviews. Trusting acts by both patient and physiotherapist make the patient-physiotherapist relationship a reciprocal trusting relationship. The constantly changing dynamic of this trust makes it relational.

The trust that practitioners have in patients, such as the trust that physiotherapists have in their patients, has not been the focus of healthcare literature. Perhaps this is because the activities that physiotherapists trust patients to perform are less apparent in medicine. Medical practitioners often use diagnostic tests and are arguably less reliant on subjective and physical assessments than physiotherapists. In addition, the active participation required of patients to perform movements and exercises is more specific to physiotherapy than to medical practice (Poulis, 2007b). One explanation of this is a concept of 'thin trust' that is attributed to new acquaintances who have reciprocal and generalized common expectations of each other within a particular context (Illingworth, 2005). That is, patients and physiotherapists may both have generalized expectations of one another as a form of 'thin trust' in the private physiotherapy practice context.

Having established that trust was present between patients and physiotherapists in my research, I next consider why and how they were trusting of each other. A number of authors have suggested that the attributes and attitude of a person being trusted are particularly significant (Baier, 1986; Illingworth, 2005; Pellegrino et al., 1991). The 'truster' is described as having faith in the character and goodwill of the trusted. To elaborate on what might constitute such character, patients as research participants have stated that honesty, responsiveness, openness, compassion, caring, demonstrations of competence, providing explanations, and the presence of rapport are features and attributes that facilitate them to trust in their practitioners (Mechanic & Meyer, 2000; Thom & Campbell, 1997; Thom et al., 2004). In my research, physiotherapists demonstrated many of these attributes.

Buchanan (2000) described 'status trust' and 'merit trust' as types of trust that patients have in healthcare professionals. His explanations of these concepts

assist to identify the specific attributes of physiotherapists and the features within interactions that supported trust in patient-physiotherapist interactions.

Status trust, defined as trust linked to healthcare professionals 'simply by virtue to their being identified as members of that profession' (Buchanan, 2000, p. 190), albeit possible, was not a focus of the findings in my research. Patients attested in their interviews that it was the personality and personal characteristics of the physiotherapist that made the interaction positive for them. These comments suggest that it was largely the physiotherapists themselves who warranted patient trust by providing patients with evidence of their personal merits. Consideration for the trust that may or may not evolve from the physiotherapist being a member of the physiotherapy profession and an employee of a specific private practice are therefore not specifically addressed in this discussion.

Based upon my findings, I believe that the trust patients had in physiotherapists was indicative of what Buchanan (2000) has termed 'merit trust'. Merit trust is based upon the 'entruster's' beliefs and perceptions of the merit of the person being trusted. Buchanan (2000) offered physicians as an example, and stated that behaviours exuding competence and dedication to the wellbeing of the patient are the most obvious demonstrations that physicians are trustworthy, therefore allowing patients to believe in the merit of the physician.

In my study, patient participants spoke consistently about the confidence they derived from demonstrations of expertise and competence from their physiotherapist. Patients valued the incorporation of anatomical models and posters, clinical explanations, use of technical language, and technical touch because they provided evidence of the physiotherapist's knowledge. In addition, patients derived confidence from physiotherapists who demonstrated competence by providing communicative direction throughout the interaction.

By leading the communication and incorporating demonstrations of their knowledge and expertise, physiotherapists engendered merit trust from their patients.

Merit trust was also powerfully established in the patient-physiotherapist interaction through adaptive, responsive communication. Demonstration of commitment to the welfare of the individual patient is considered an important dimension that facilitates merit trust (Buchanan, 2000). It has also been recognized that patients tend to trust their practitioner when they exhibit 'caring behaviours' (Mechanic & Meyer, 2000; Roter & Hall, 2006). Physiotherapist use of adaptive communication demonstrated responsiveness, care, and concern for each patient as an individual. Patient participants verified these findings by explaining the benefits of feeling cared for as an individual, and acknowledging the harmonious relationships that they developed with their physiotherapists through adaptive communication.

Touch, in particular, had an influential role in the establishment of merit trust in patient-physiotherapist interactions. In my research, touch was observed and perceived by participants to be adapted and adjusted to the needs of the individual patient. In interviews, patients explained the value or merit that they attached both to expertise demonstrated through technical touch, and to caring touch that expressed empathy and concern for the individual patient. Technical touch, used as part of assessment and treatment techniques, conveyed physiotherapists' knowledge of the body; caring touch, demonstrated through actions such as a rub on the patient's leg, conveyed genuine care and empathy toward patients. These touching behaviours, in turn, resulted in patients trusting physiotherapists for their merits. A role in developing trust further highlights the significance of touch in patient-physiotherapist interactions.

Many other 'caring behaviours' were observed as adaptive communicative elements in the patient-physiotherapist interactions. Clear examples in my findings were eye contact, actively listening, and adjusting body positions. These relational communicative elements were demonstrations of physiotherapists caring for patients as individuals and therefore precipitated another form of merit trust. These identifiable caring behaviours, as well as particular demonstrations of competence, extend knowledge regarding the specific attributes that warrant merit trust in the patient-physiotherapist interaction.

In summary, patients and physiotherapists were trusting of each other in their patient-physiotherapist interactions. I have described the concept of trust and used my research findings, combined with Buchanan's (2000) notion of merit trust, to detail attributes and behaviours that constituted the relational trust that was a central and defining component of patient-physiotherapist interactions. Understanding trust in patient-physiotherapist relationships adds to knowledge about communicative features of relationships described in a relationship-centred approach. Together the ideals of relationship-centred care and merit trust provide a broad picture of the nature of the patient-physiotherapist relationship in private practice.

Chapter summary

In this chapter I have established that building and sustaining a relationship are central to the patient-physiotherapist interaction. I have used a relationship-centred approach to explain my results and, in so doing, have provided empirical evidence to support many of the characteristics of relationship-centred care described in the literature. I contend that relationship-centred care is an appropriate alternative approach to bridge the theory-practice gap between the promoted patient-centred and biopsychosocial approaches and my empirical

findings. This relational account of patient-physiotherapist interaction is richer than the standard approaches to healthcare interaction where power or direction is attributed to one or other party. In addition, by combining the ideals of relationship-centred care with explanations incorporating trust and power, I have provided a new, comprehensive, and detailed picture of the important nuances in patient-physiotherapist relationships in private physiotherapy practice.

In my concluding chapter I consider how my findings are relevant and useful for physiotherapy education and practice. Specifically, I promote a relationship-centred approach that incorporates understandings about trust as a possible framework to support and explain how physiotherapists interact with their patients, particularly in private practice.

Chapter seven: Implications and conclusion

Introduction

In this thesis I explored the interaction between patient and physiotherapist to answer the question: 'how do patients and physiotherapists interact with each other in the private practice setting?' My research was developed as a result of my personal experiences as a practising physiotherapist, and in response to the growing interest in the practice and theory of interaction in physiotherapy.

Previous research has predominantly focussed on discrete components of interaction such as goal setting and decision making, the perspectives of both patients and physiotherapists about aspects of interaction, and has been undertaken in hospital or outpatient settings. I aimed to add to this knowledge by providing empirical understandings about patient-physiotherapist interactions in private practice. I also sought to address the potential theory-practice gap by considering my findings in relation to the widely promoted approaches for healthcare interactions. An overall aim was to provide insight into whether these approaches are relevant and applicable to clinical physiotherapy practice.

To achieve inductively derived descriptions of patient-physiotherapist interactions, the research methodology incorporated aspects of both ethnography and grounded theory. I collected observational and interview data to provide a picture of interactions that encompassed applicable perspectives. Data analysis, informed by principles of grounded theory and thematic analysis, was undertaken iteratively using constant comparison. Prominent elements of the interview and observational data were identified and combined through a process of concept mapping. This layered analytic process ultimately led to two central themes reported in Chapters four and five. These themes, substantiated

by specific elements of communication, were 'physiotherapist-led communication' and 'adapting to build rapport'.

I concluded that interactions in private practice physiotherapy incorporated both physiotherapist-led and adaptive communication. I also proposed that achieving clinical, technical aspects of physiotherapy practice, as well as demonstrating care and empathy, are central to communication in private practice physiotherapy interactions. These results did not align with recognized healthcare approaches such as biopsychosocial and patient-centred care, largely because these approaches do not incorporate clear descriptions of the adaptive, responsive communication that was central to my findings. Hence, I sought alternative conceptual explanations.

In Chapter six I used relationship-centred care and ideas about trust to frame the findings. Relationship-centred care supports and explains my findings because it centres on the relationship and incorporates both functional and responsive characteristics that were inherent in my themes 'physiotherapist-led communication' and 'adapting to build rapport', respectively. In addition, trust was integral to the findings, and descriptions of trust assisted to further contextualize how elements of interaction, such as those demonstrating therapist expertise and caring behaviours, developed and sustained trust in the patient-physiotherapist relationship.

In this final chapter I consider the implications of my findings for the physiotherapy profession, particularly with regard to philosophical, practical, and educational aspects of physiotherapy. I explain the significance of my findings for physiotherapists, patients of physiotherapists, and physiotherapist educators. I also elaborate on the contributions that frameworks of relationship-centred care and trust make to knowledge about interactions in physiotherapy.

In addition, I outline the methodological contributions of my research design to qualitative healthcare research. Finally, I explore the strengths and limitations of this enquiry and offer suggestions for future research before providing my final conclusions.

Implications for the physiotherapy profession

Physiotherapy as a profession comprises an occupational group of highly trained, competent people who have an exclusive knowledge base, autonomy of practice, and are dedicated to serving the public by practising their chosen field (Popkewitz, 1994; Richardson, 1999). Growth and development of the profession relies upon maintaining a base of knowledge and credibility of practice (Richardson, 1999). To achieve these professional requirements physiotherapy needs research to progress knowledge, and education to translate knowledge into practice. Moreover, professions have professional paradigms and philosophical foundations that influence the way that practice is performed (Richardson, 1999). In this section I consider the significance and implications of my research findings on the philosophical, practical, and educational aspects of the physiotherapy profession.

Recognizing the overlap between each of these aspects of the physiotherapy profession, I first discuss the impact of my findings on theoretical and philosophical aspects of physiotherapy. Second, I consider how the elements of communication inherent in my findings, as well as frameworks of relationship-centred care and trust, may assist and prepare physiotherapists to interact with patients in private practice. The significance of the research for both physiotherapists and their patients is explained. Third, I make suggestions for possible educational strategies that might be useful in communication

curriculum in physiotherapy, including consideration for the use of reflective practice as an important tool to achieve change.

Implications for theoretical and philosophical aspects of physiotherapy

Interaction is an integral aspect of physiotherapy (Gyllensten et al., 1999; Klaber Moffett & Richardson, 1997). Thus, the increasing evidence of a gap between espoused patient-centred and biopsychosocial approaches and the practice of interactions in physiotherapy has significant implications (Cruz et al., 2012; Josephson et al., 2015; Opsommer & Schoeb, 2014). It is possible that patient-centred and biopsychosocial approaches are inadequate or inappropriate as theories to describe and support the realities of interaction in physiotherapy practice. This likely theory-practice gap means that interaction in physiotherapy may be lacking an appropriate theoretical framework. A theory-practice gap means that educators may be unsure how to teach physiotherapists to interact with patients in a patient-centred manner, and is also likely to impact upon the development of interactional aspects of the physiotherapy profession.

Appropriate theory that supports interactions in physiotherapy practice is required to provide a platform and framework for education and development of this integral part of the physiotherapy profession.

Theory enables better understanding or conceptualization of a situation, presents facts in a detailed and coherent manner, and should be applicable to practice (Vansteenkiste & Sheldon, 2006). As stated in Chapter two, good theory provides descriptions of established patterns derived from empirical research, and also presents an explanation for the causes and meanings of the patterns established (Van de Ven, 1989). Although not sufficient to be termed a theory, my descriptions of a relationship-centred approach and trust, combined with elements of communication derived from my research, go some way toward

generating a framework that is applicable to the practice of interaction in the private physiotherapy setting.

In contrast, patient-centred and biopsychosocial approaches to interaction in physiotherapy are not derived from empirical research. Authors have criticized the lack of consensus and the absence of clear, clinically applicable descriptions of biopsychosocial and patient-centred theories that make them difficult to operationalize (McLaren, 1998, 2006; Nolan, Davies, Brown, Keady, & Nolan, 2004). Indeed, a recent landmark publication has presented suggestions to address the lack of evidence-based support for the biopsychosocial approach in medicine (Smith et al., 2013). According to descriptions of good theory (Van de Ven, 1989; Vansteenkiste & Sheldon, 2006), these limitations preclude patient-centred and biopsychosocial theories from being useful theories for the practice of interaction in physiotherapy.

In addition, authors have suggested that the physiotherapy profession remains underpinned by a biomedical, practitioner-centred discourse that is likely to be limiting physiotherapists' ability to engage with patients in a patient-centred manner (Mudge, Stretton, & Kayes, 2013; Trede, 2006). This furthers the argument against patient-centred care and biopsychosocial approaches being appropriate frameworks for interactions in physiotherapy. Moreover, findings from my interviews with physiotherapist participants highlighted that physiotherapists were aware of biopsychosocial and patient-centred approaches, but had not considered how to implement them in practice. In addition, research that sought to implement a biopsychosocial approach in physiotherapy has reported that physiotherapists struggled to understand and address psychosocial aspects of individual patients' presentations (Sanders et al., 2013). It seems that although physiotherapy as a profession espouses patient-centred and biopsychosocial approaches, the reality is that physiotherapists are unsure

how to implement these approaches, and the profession remains engrained in a practitioner-centred, biomedical paradigm.

Based upon this literature and my findings, I suggest that the physiotherapy profession, particularly the private practice and possibly outpatient musculoskeletal aspects of the profession, consider reframing descriptions of interactions within a relationship-centred approach that incorporates the development of trust. My empirical findings show that physiotherapists in the private practice setting are already developing trust with patients and achieving many of the ideals of relationship-centred care. I recognize the challenges of changing the mindset of practitioners from the current biomedical, practitioner-centred view to a relational one that incorporates the functions of clinical physiotherapy alongside the responsive, informative, participatory, and facilitatory characteristics of therapeutic relationships (Roter, 2000). Ultimately, more research evidence and shifts in the focus of education are required to achieve a relationship-centred position. I do believe, however, that a potential shift to relationship-centred care is more feasible than achieving patient-centred care in practice because relationship-centred care incorporates the functional elements of interaction, similar to those of a biomedical, practitioner-centred paradigm. Furthermore, a relationship-centred approach may not require practical changes; my findings suggest that characteristics of relationship-centred care are already present in patient-physiotherapist interactions in the private practice setting.

Having discussed the possible theoretical implications of my findings, I now consider how this research might advance the practice of interactional aspects of physiotherapy.

Implications for physiotherapy practice

The findings from my research provide clear examples of communicative techniques used when physiotherapists interact with patients in private physiotherapy practice. Furthermore, relationship-centred care can be considered a potential framework to guide physiotherapists in their communicative practice. Although they were blended differently for each individual interaction, the patterns of communication used by physiotherapists in this research were consistent in that they incorporated both directive and adaptive styles of communication. These patterns of communication allowed physiotherapists to achieve their clinical goals as well as provide care for patients as individuals. That is, patterns of communicative practice were functional yet responsive to individual patients' needs.

Having these insights has the potential to transform how physiotherapists in private practice conceptualize interactions with their patients. For example, physiotherapists can understand that communication in the interaction functions to build rapport as part of a relationship that is both therapeutic and caring. The descriptions of elements of communication are examples that could assist physiotherapists to understand how they are practising, and to reflect on elements of communication that they may not be incorporating into their communicative repertoire.

My discussion about how findings related to the relationship-centred approach highlighted some areas that physiotherapists could improve communication with patients. In particular, patient participation through involvement in decision making and goal setting was notably absent in the observed interactions. There is considerable evidence that patient involvement in a shared decision making process, although not widely implemented, improves patient

satisfaction and outcomes (for example, Bainbridge & Harris, 2006; Dierckx et al., 2013; Jones et al., 2014). Hence, including patients in decision making processes would likely increase patient participation and enhance patient-physiotherapist relationships. Physiotherapists in private practice as well as physiotherapy educators might contemplate how they can incorporate shared decision making processes into their interactions with patients.

The outcomes of this study have provided the explanations and conceptual framework that, as a physiotherapist, I was seeking prior to commencing the research. By elucidating the role of interaction and the development of a trusting relationship, my findings have explained what I experienced in my clinical practice; they have also provided a framework to assist me and other physiotherapists to articulate and reflect upon how we interact with patients.

My findings also have significance for patients. Physiotherapists can use knowledge derived from my research to incorporate and reflect upon patient perspectives of their interactions. In addition, if physiotherapists seek to interact in a relationship-centred manner, they should be sensitive to communicative techniques that are responsive to the needs of the individual patient. In short, patients will benefit from trusting relationships with their physiotherapists. Finally, the knowledge derived from my findings highlights the patient role in the interaction, particularly the power of choice that patients have when interacting with physiotherapists in private practice. Knowledge from this research provides patients with an opportunity to understand and reflect on their own role in their interactions with physiotherapists. If implemented into physiotherapy practice, the results of this research would be significant for both physiotherapists and patients of physiotherapists in private practice.

Implications for physiotherapy education

In this section I discuss how my findings could impact on the education of both students and physiotherapists about interacting with patients. I propose that achieving trusting, relationship-centred interactions with patients, and expanding physiotherapists' understandings of commonly utilized communicative elements of practice, should be emphasized. I also advocate that sound theory to explain and underpin the interactional aspects of practice is required. Finally, I provide suggestions about educational practices that might assist physiotherapists to recognize, incorporate, and evaluate relationship-centred values and adaptive elements of communication.

I have proposed a shift in framework for interactional aspects of physiotherapy practice. Achieving this shift from biomedical, practitioner-centred approaches to a relationship-centred approach poses a challenge to physiotherapy educators. Accomplishing any type of paradigm shift in healthcare is difficult because professional education is usually founded upon the underlying beliefs of the dominant paradigm (Anderson & Funnell, 2005). In this case, however, it could be argued that, unlike the difficulties physiotherapists are having implementing a patient-centred, biopsychosocial approach (Mudge et al., 2013; Sanders et al., 2013), physiotherapists are already achieving relationship-centred and trusting alliances with their patients, as suggested by my findings and those of Tasker and colleagues (2012). That is, it may be a theoretical shift rather than a practice-based one. Having a planned, coherent framework is regarded as essential for teaching communication skills (Makoul, 2003). The benefit of relationship-centred care as an approach is that it may already be embedded in patient-physiotherapist interactions.

In addition to an approach that provides conceptual understandings, educating physiotherapists and physiotherapy students about interactional aspects of practice requires knowledge about the specifics of communication in physiotherapy. In their article ‘Teaching and learning communication skills in physiotherapy: What is done and how should it be done?’ Parry and Brown (2009) highlighted several gaps in evidence that impact upon the development of educational recommendations with regard to communicative and interactive aspects of practice. One of these knowledge gaps involved the lack of evidence about specific communication skills in patient-physiotherapist interaction. Moreover, in a systematic review of evidence for educational programmes to improve communication in allied health professions, Parry (2008) concluded that further empirical understandings about communicative practices in allied health were required to assist planning and delivery of communication training.

In Chapters four and five I provided examples of the types of communication that physiotherapists were using when interacting with patients in private practice. The specific types of communication, as well as illustrations of when and how these types of communication are used in physiotherapy practice, provide detailed components to incorporate into educational curricula. For example, I recommend that in addition to practising the specifics of physiotherapist-led communication, content of communication skills courses should include adaptive elements of communication such as touch, body language, eye contact, casual conversation, and humour. Examples of the ways that these elements of adaptive communication are used by physiotherapists to build rapport could be explained and demonstrated to students for later practise and implementation.

It is recommended that teaching of communication skills involve experiential opportunities for students with formative feedback provided by expert staff (Parry & Brown, 2009). I suggest that this type of teaching needs to be

supplemented with an appropriate theoretical framework to explain how elements of communication embedded in the patient-physiotherapist interaction are integrated to form a trusting relationship between patient and physiotherapist. Theoretical frameworks assist learners to understand and conceptualize what they are learning. In the case of teaching adaptive communication skills, a relationship-centred approach can be used to explain physiotherapists' roles in demonstrating responsiveness and building rapport with patients.

Physiotherapist participants in my research explained adaptive communication as being intuitive and resulting from experience interacting with different people. Intuition and experience are associated with expertise and may therefore pose a challenge to teaching adaptive communication (Benner, 1984; Jensen, Gwyer, Shepard, & Hack, 2000). There is, however, some consensus that with appropriate education it is possible for practitioners to improve and adapt their communicative abilities (Moore, Rivera Mercado, Grez Artigues, & Lawrie, 2013; McGilton et al., 2009; Pinto et al., 2012). Communication skills training should therefore endeavour to embrace elements of communication associated with expertise, such as those described within my theme 'adapting to build rapport'.

The role of reflective learning

Some strategies for incorporating responsive and caring types of communication into curriculum have been proposed. In particular, to achieve a relationship-centred approach to interacting with patients it is suggested that practitioners need to be reflective learners in an environment that fosters the creation of relationship-centred values (Tresolini & The Pew-Fetzer Task Force, 1994). This section explores reflective learning as an educational tool for physiotherapists to

question their assumptions, build an awareness of patients' perspectives, and incorporate responsive and relationship-centred values into their practice.

Self-reflection or reflective practice is an increasingly used tool in healthcare and physiotherapy education (Mamede & Schmidt, 2004; Scully, 2011). The Physiotherapy Board of Australia's (2014) Code of Conduct states that professionalism includes self-reflection. In addition, therapist reflection that assists evolution of practice is considered to be a component of expert practice in physiotherapy (Jensen et al., 2000). Self-reflection aims to transform practitioners' insights and understandings regarding the clinical care that they are providing, and should result in practical change (Greenfield et al., 2015). This type of reflection is therefore a tool that physiotherapists could use to critically interpret the interactional aspects of their practice.

To incorporate reflective learning, an education programme must promote introspection and openness and provide opportunities for reflection (Tresolini & The Pew-Fetzer Task Force, 1994). Didactic teaching is certainly insufficient (Tresolini & The Pew-Fetzer Task Force, 1994). Providing time for learners to reflect on experiences, probing questions by clinical instructors, and written reflections are all documented approaches to achieving self-reflection (Plack, 2006; Rosenbaum, Ferguson, & Herwaldt, 2005). Demonstrating the efficacy of self-reflection, a process of critically reflective insights has achieved a transformation of practice style in a group of physiotherapists (Trede, 2012). I propose that a learning environment that fosters reflective practice is essential for the development of communicative elements of interactions with patients, particularly adaptive communicative elements. In addition, some form of reflective practice on the part of educators, practitioners, and students is required for the transformation of the current biomedical, practitioner-centred approaches to a relationship-centred approach.

In this section I have explained how my results could assist education in two ways. First, my findings provide detailed descriptions of each element of communication occurring in private physiotherapy practice. Second, my discussion presents the clinically relevant ideals of a relationship-centred approach and trust. The relationship-centred and trust frameworks provide explanations for the purposes of communication during patient-physiotherapist interactions. These two key theoretical contributions are expanded upon in the next section.

Contributions of my research

This section details the scholarly contributions generated by my research. I first summarize the theoretical contributions before outlining how some aspects of my methods have added to knowledge about conducting qualitative research in healthcare.

Theoretical contributions

Knowledge about the practice of communication in physiotherapy derived from empirical observational data is arguably the most significant contribution that this research has provided. In her seminal article emphasizing the relationship as central to interaction and outlining relationship-centred care, Roter (2000) wrote: 'the primary methodological challenge to the field is the transition from the conceptual underpinnings of relationship-centred care to operational indicators that are observable and measurable elements of communication' (p. 8). It is indeed challenging to operationalize conceptual approaches to interaction. I have documented observable elements of communication that I consider to be 'operational indicators' of relationship-centred care in physiotherapy. For example, caring touch is a clear communicative indicator of

the responsive characteristic of relationship-centred care that can be observed and measured as an element of communication. My methodological approach has hence provided a means of generating operational indicators of interaction that are indicative of relationship-centred care. Moreover, this research has generated clinically applicable information that details a relationship-centred approach in the physiotherapy context.

My findings have also extended knowledge about trust in the patient-physiotherapist relationship. In my discussion I incorporated the established ideals of merit trust (Buchanan, 2000). I used my empirical findings to explain how elements of communication that physiotherapists incorporated, such as the use of technical and caring touch, expressions of clinical knowledge, and use of eye contact, demonstrated to patients that physiotherapists had expertise and exhibited caring behaviours that constituted such merit trust.

This thesis contributes knowledge about communicative practice in physiotherapy. In so doing, it also contributes knowledge about the nature of the broader practice of physiotherapy, emphasizing caring and human values as well as the relations that underpin physiotherapy professional practice. Finally, my conclusions extend discussion about whether and how theoretical approaches are applicable to the practice of physiotherapy.

Methodological contributions

My methods contribute to the field of qualitative research in healthcare. As is increasingly common, I combined methodologies: in this instance incorporating aspects of ethnography and grounded theory to successfully achieve appropriate data and relevant outcomes. Thus, my study provides a further example of how these two methodologies can be combined. In addition, the inclusion of graphic

elicitation data provides other researchers with an example of how this type of data can be a useful adjunct to qualitative interviews. More significantly, my descriptions of the experience of having a dual identity as a clinician-researcher provide insights for other qualitative health researchers.

Specific ethical and methodological challenges arose from my dual identity as a physiotherapist and qualitative researcher. Researching an aspect of one's own profession is becoming increasingly common and requires some carefully considered planning and negotiations (Asselin, 2003). For example, during data collection for this project physiotherapist and patient participants sometimes asked for my professional opinion as a physiotherapist. I became increasingly reliant on the use of reflexivity to assist me to negotiate these challenging moments. A colleague and I framed these challenges as participant misconceptions and published a paper titled 'Reflexivity and the clinician-researcher: managing participant misconceptions' (see Appendix B). In the article we presented detailed practical examples of how we negotiated participant misconceptions using reflexivity. We used our examples to highlight the many challenges encountered by health professionals qualitatively researching their own field, and emphasized the value of reflexivity in addressing these challenges.

Research strengths and limitations

Although there is some debate, the value and integrity of a qualitative research project is generally appraised by considering the trustworthiness of the research (Angen, 2000; Finlay, 2002; Guba, 1981; Kisely & Kendall, 2011; Petty, Thomson, & Stew, 2012b). Trustworthiness is the confidence that those assessing a research project have in the study and its findings, or a study's 'truth-value' (Angen, 2000; Robson, 2011). Four components of trustworthiness commonly

considered in qualitative research are: credibility, transferability, dependability, and confirmability (Guba, 1981; Petty et al., 2012b). I recognize that authors have criticized the use of specific criteria to assess the quality or rigour of qualitative research, observing that this process relates to a positivist framework and fails to incorporate the researcher's subjective involvement (Angen, 2000; Johnson & Waterfield, 2004). Nevertheless, a flexible framework specifically developed for qualitative research is useful to support critical appraisal of qualitative research. In this part of my conclusion I consider how I sought to address each component of trustworthiness through the research methods and, in so doing outline the research strengths and limitations.

The credibility of qualitative research is considered the 'truth value' of the research and relates to the degree of plausibility of the findings (Guba, 1981; Petty et al., 2012b). My methods incorporated strategies such as prolonged engagement, persistent observation, triangulation, and the use of a reflexive research journal that are reported to assist the credibility of a study (Guba, 1981; Petty et al., 2012b). Another frequently stated technique to improve the credibility of research is member checking, where participants are requested to corroborate that the findings represent their perspectives (Cohen & Crabtree, 2008). Member checking was not formally incorporated into the methods of this research, as it assumes a fixed reality, and can lead to confusion because participants may, later, present a different perspective from that in their original interview (Angen, 2000). Implementing specific strategies such as prolonged engagement and triangulation has arguably assisted the credibility of this project. The real measure, however, is whether the findings presented are sensible, believable, and clinically relevant (Greenhalgh & Taylor, 1997). Hence, I have presented extensive data in the results chapters and related my findings to physiotherapy theory and practice in order to increase the credibility and applicability of the research.

Transferability refers to how readily findings can be extrapolated to other settings and contexts (Guba, 1981). Transferability is the main limitation of this research: the findings only relate to the private practice context. Reduced transferability is a common limitation in qualitative ethnographic research because the setting and context need to be specific and contained in order to achieve rich detailed data and findings. Because physiotherapy is a diverse profession, the implication of this specificity is that my results are unlikely to be universally applicable to other settings and locations. However, the rich descriptions of the private physiotherapy context that I have provided in Chapter three should assist others to establish similarities or differences with their specific context and setting (Guba, 1981). As detailed in Chapter three, I attempted to maximize the transferability of the research by choosing the most common workplace in Australia, private practice, as the setting. I also recruited two private practices with diverse clientele, and physiotherapist participants with a range of backgrounds and levels of experience to increase the relevance of my findings.

A third component of trustworthiness is dependability. Dependability refers to the stability of the research process or, how likely it is that someone else could perform the same research and attain similar results (Guba, 1981; Petty et al., 2012b). Dependability is achieved through clear descriptions of the decisions made throughout the research process, often referred to as providing an audit or decision trail (Koch, 2006). Use of a field journal, as I did throughout this project, provides researchers with clarity about their decision making processes (Koch, 2006). Although I used components of a variety of methodologies and methods, the reader can ascertain the dependability of the research based upon the clear steps of the research process described in Chapter three.

Finally, confirmability refers to how readily the results can be considered free from researcher bias or how well the research process minimized researcher bias (Guba, 1981). Two methods are often promoted to maximize confirmability within qualitative research: triangulation and reflexivity (Finlay, 1998; Petty et al., 2012b). Both of these techniques were integrated into the methods of this research. Multiple data sources, as well as other researchers (supervisors) independently analyzing some data, provided triangulation. Furthermore, I considered reflexivity to be integral to the success of my research. In addition to many conversations with other qualitative researchers about their experiences, I wrote regularly in my research journal as a way of fostering reflexive thinking. I sought to increase confirmability by making my biases as a physiotherapist researching physiotherapy practice explicit throughout the entire process.

The strength of my study lies in the incorporation of multiple data sources that have assisted to provide rich, thick descriptions of interactions in physiotherapy private practice. The analysis of the data associated with these descriptions has generated clear elements of communication that contribute to knowledge about interaction in physiotherapy.

There were, however, limitations resulting from my emphasis on generating rich data and the associated small sample size. Due to the research logistics and volume of data generated, I was unable to observe interactions between a patient and a physiotherapist over a prolonged period. The evolving nature of interactions and relationships over time were therefore not fully captured in my study. Moreover, including only two private practices and nine physiotherapist participants meant that interactional differences between physiotherapists and patients with specific characteristics could not be examined. For example, the impact of gender differences and cultural backgrounds on the interaction were unable to be analyzed. Some likely influences of gender roles, cultural

backgrounds, and levels of physiotherapist experience were alluded to during my research. Examining such influences are potential avenues for further research.

Inductive explorative research such as this can generate a multitude of findings, and a further limitation is that I was unable to explore all of these findings in depth. For example, communicative elements such as touch and humour and the inclusion of an active treatment component were findings that could have been explored in considerably more detail. To do so, however, would have compromised my presentation of a comprehensive picture of all elements of interaction that were derived from data analysis. I acknowledge that there are many ways that findings from this research could have been analyzed and presented. To maintain consistency, I focussed upon achieving my research aims to explore the entirety of the patient-physiotherapist interaction and consider how the findings related to approaches to interacting with patients. Hence, the initial aims and the methodological choices that were made guided the final presentation of results.

In addition, it was evident that experienced practitioners were more proficient at achieving some elements of communication, particularly those outlined in the 'adapting to build rapport' theme, than their novice colleagues. In interviews, experienced practitioners were more adept at explaining how they incorporated adaptive communication as they had often reflected more upon their communicative techniques; they provided valuable insights for my interview data. Considering differences between novice and expert practice, however, was not a goal of this research, and comparative analysis was therefore not undertaken to determine differences between interactions of novice and expert practitioners. This could be considered a limitation, particularly when considering educational implications.

Future research

The findings of this research provide abundant opportunities for future enquiry. Fundamentally, there remains a gap between the theory and practice of interaction in physiotherapy that is largely the result of a lack of empirically derived knowledge about how interactions between patients and physiotherapists occur. I recommend four main avenues for future exploration into interaction in physiotherapy.

Given that transferability is a limitation of this research, I first propose that similar qualitative research be undertaken in a variety of physiotherapy settings in different locations. Exploratory, inductive, qualitative research that includes observational data will add further empirical knowledge about how interaction occurs in physiotherapy practice. Ideally, observations of practice over time would be included to allow the generation of knowledge about how patient-physiotherapist relationships evolve. In contrast to interview and focus group research that provides accounts of a phenomenon, observational data generate findings that are founded upon actual interactions (Schoeb, 2009). More enquiry of this type will extend understanding about the elements and processes of interaction in various physiotherapy settings.

Observational data can be analyzed in numerous ways. My second proposed avenue for future research is for data collection and analysis to be undertaken with the aim of specifically exploring individual elements of communication in physiotherapy. For example, conversation or discourse analysis would provide detailed understandings about episodes of casual conversation in patient-physiotherapist interactions. Currently, as elements of communication in physiotherapy, goal setting processes have received the most attention (Parry, 2004; Schoeb, 2009; Schoeb et al., 2014). Touch is becoming another area of

increasing research interest (Bjorbaekmo & Mengshoel, 2016; Roger et al., 2002). Further knowledge about these elements of communication would provide the physiotherapy profession with specific understandings about how each communicative element can be incorporated into educational programmes and clinical interactions with patients.

Third, the implementation of relationship-centred care in physiotherapy practice requires research exploration. As I established in Chapter six, functional, informative, and responsive characteristics of relationship-centred care were all clearly evident in my study. The participatory and facilitative characteristics, however, were less apparent, and provide a starting point for further investigation. A form of participatory action research encouraging physiotherapist facilitation and patient participation in patient-physiotherapist relationships might be appropriate. Moreover, research providing insight into the feasibility, applicability, and value of a relationship-centred approach to support the practice of interacting with patients in physiotherapy would be beneficial. Finally, educational research is also required to ascertain how to effectively teach students and physiotherapists about interacting in physiotherapy. This research would also need to consider how to evaluate the proposed teaching methods.

In summary, I consider that the research reported in this thesis is a starting point that has generated a holistic understanding of current interactional practice in a specific physiotherapy setting. This research was not about optimizing or assessing the quality of interaction; rather it has provided a foundation of knowledge about interactions between patients and physiotherapists that might assist future research to consider the characteristics of ideal interactions in physiotherapy.

Conclusion

This thesis was a qualitative exploration of interactions between patients and physiotherapists in private practice. Multiple sources of data were collected to incorporate the perspectives of the observer, patients, and physiotherapists. I presented findings derived from a layered analytical process as two central themes that were intrinsic to all the data: 'physiotherapist-led communication' and 'adapting to build rapport'. These findings did not correlate with established approaches to healthcare interaction and, as a consequence, I have argued that a relationship-centred approach and merit trust are instrumental in explaining my findings and offer alternative explanations for interaction in physiotherapy. These approaches, incorporating empirically derived elements of communication, are representative of how patients and physiotherapists were interacting in private practice in Melbourne and present a starting point for new insights and continued development in the growing field of interaction in physiotherapy.

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Appendices

Appendix A

Hiller, A., Guillemin, M., & Delany, C. (2015). Exploring healthcare communication models in private physiotherapy practice. *Patient Education and Counseling*, 98(10), 1222-1228. doi: 10.1016/j.pec.2015.07.029

Appendix B

Hiller, A. J., & Vears, D. F. (2016). Reflexivity and the clinician-researcher: managing participant misconceptions. *Qualitative Research Journal*, 16(1), 13-25. doi: 10.1108/QRJ-11-2014-0065

Appendix C

Interview guides for physiotherapist and patient participants

Appendix D

Plain language statements and consent forms for physiotherapist and patient participants

Appendix E

Information for recruiters of patient participants

Appendix F

Assessment form for University of Melbourne Master of Physiotherapy students

Appendix A: Publication in Patient Education and Counseling

(Accepted author manuscript)

Exploring healthcare communication models in private physiotherapy practice

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Disclosure

All authors contributed substantially to the conception and design of the study, Amy Hiller acquired and transcribed the data and all authors contributed to data analysis. Amy Hiller drafted the first version of the article with Marilys Guillemin and Clare Delany revising it critically and assisting with subsequent versions and editing. All authors considered appropriate revisions and have approved the final article as submitted.

Abstract

Objective: This project explored whether models of healthcare communication are evident within patient-physiotherapist communication in the private practice setting.

Methods: Using qualitative ethnographic methods, fifty-two patient-physiotherapist treatment sessions were observed and interviews with nine physiotherapists were undertaken. Data were analysed using thematic analysis.

Results: In these clinical encounters physiotherapists led the communication. The communication was structured and focussed on physical aspects of the patient's presentation. These features were mediated via casual conversation and the use of touch to respond to the individual patient. Physiotherapists did not explicitly link their therapeutic communication style to established communication

models. However, they described a purposeful approach to how they communicated within the treatment encounter.

Conclusion: The communication occurring in the private practice physiotherapy treatment encounter is predominantly representative of a 'practitioner-centred' model. However, the subtle use of touch and casual conversation implicitly communicate competence and care, representative of a patient-centred model. Physiotherapists do not explicitly draw from theories of communication to inform their practice.

Practice implications:

Physiotherapists may benefit from further education to achieve patient-centred communication. Equally, the incorporation of casual conversation and the use of touch into theory of physiotherapy patient-centred communication would highlight these specific skills that physiotherapists already utilise in practice.

Keywords:

Communication; patient-centred care; communication models; physiotherapy; private practice; touch; casual conversation.

1. Introduction

It is well established that communication is fundamental to healthcare practice [1]. Communication that enhances the patient-practitioner relationship is integral to achieving desired treatment outcomes [2-4] and patient satisfaction [5-8]. In the current climate of evidence-based healthcare, communication, like other aspects of therapeutic treatment, should be purposeful, goal oriented and based on evidence from empirical studies, practitioner experience and theoretical paradigms [9, 10]. For example, Smith and colleagues have proposed an evidence-based method for implementation of the biopsychosocial model [11] and other authors have advocated the need to match communication theory with practice [12, 13].

Two established models of healthcare communication are the physician- or practitioner-centred model and patient-centred care [14, 15]. These models

incorporate a particular focus of the interaction, and contain specific elements including the overall structure, questioning style and type of content [16]. Other less visible elements of these communication models include underlying assumptions about roles and responsibilities, power and authority, and the type of relationship that is valued and supported between patient and practitioner [17, 18]. Despite their differences, these models are not considered separate entities and both may be necessary in varying aspects of the clinical encounter.

1.1 The practitioner-centred model

The physician-, doctor-, disease- or practitioner-centred model is a traditional communication model for healthcare consultations as evidenced by research in the twentieth century [14, 19, 20]. The biomedical model is the content-based model that aligns with this approach, focussing on biological determinants, causes and explanations for the presenting condition [21]. It has a strong scientific basis leading the practitioner to focus on making a diagnosis and providing care aimed at identifying and then curing the practitioner-identified problem [21, 22]. Communication features of a practitioner-centred model include: specific, structured, closed and direct questions from the practitioner; a focus on biological processes as a cause of the presenting condition; and a relationship which is overtly directed and controlled by the practitioner's discipline-specific biomedical agenda [7, 21].

1.2 The patient-centred model

The model of patient-centred care emphasises the need to gather information and tailor treatment according to the individual patient's needs and perspectives [23]. Patient-centred communication is the process required to achieve patient-centred care. Correlating with a biopsychosocial model for content of communication, biological, social and psychological aspects of the patient's presentation are all considered in a patient-centred interview, incorporating both the patient's narrative and experiences [19, 24, 25]. Rather than imposing these three elements to pre-emptively frame the communication, however, patient-centred care denotes that the practitioner takes their cue as to what is important to patients themselves [23]. In a seminal review Mead and Bower [15] describe five key dimensions of the patient-centred model of communication: achieving a biopsychosocial perspective; showing consideration and respect for

the patient as an individual; sharing information, decision-making, power and responsibility; prioritising the patient-practitioner relationship as a therapeutic alliance and self-awareness of the practitioner. Communication in this model is therefore accommodating with increased patient input, equalising of power sharing, open questions and content centring upon what the patient considers to be important from a biopsychosocial perspective.

Despite frequent descriptions of these models of healthcare communication in the literature, there has been less consideration of how they are interpreted by different health professions and enacted or operationalized in everyday clinical practice [8]. Awareness of communication in practice seems particularly important for physiotherapy because of its reliance on active patient involvement as well as generating trust, motivation and partnership between therapist and patient to achieve active goals of care [26].

Physiotherapists, like other health professionals, draw upon theory and evidence to guide clinical practice. Although physiotherapy literature and clinical guidelines strongly promote patient-centred care as best practice for achieving these therapeutic goals [27-31], the limited available evidence suggests that physiotherapy communication aligns more closely with a practitioner-centred model. For example, Opsommer and Schoeb [32] highlight that physiotherapists' focus on the patient's pain experience and struggle to elicit and understand the patient's perspective, and Cruz and colleagues [33] note characteristics of a practitioner-centred, biomedical model whereby the patient is expected to comply passively with prescribed exercises and advice.

This research aimed to add to previous literature through observation of communicative practice and discussion with physiotherapists about their interactions in the context of the private practice clinical setting. In this environment, patients consult physiotherapists as for-profit primary practitioners in a time-pressured environment regarding a specific physical problem [34]. During this time the physiotherapist seeks to assess, treat and provide continued home management strategies. The research goals were first to examine whether and how established models of healthcare communication are incorporated into these one-on-one consultations and second to examine physiotherapists' interpretation and understanding of their clinical communication.

2. Methods

The data presented in this research report derives from a qualitative ethnographic project exploring how patients and physiotherapists interact in the private practice setting. Interpretive and critical paradigms informed data collection and analysis [35]. This research therefore sought to understand how physiotherapists communicate with their patients, and to critique how their communication style and practice relates to or represents communication models. Fifty-two patient-physiotherapist consultations were observed and nine interviews were subsequently completed with physiotherapists by the first author, AH.

The settings for this research were two independent private physiotherapy practices in metropolitan Melbourne, Australia. Physiotherapy practices and physiotherapist participants were recruited as a purposive convenience sample. Private practice was chosen as the research setting because it is the predominant workplace for physiotherapists in Victoria [36]. Private practice is also an environment that enables observation and distillation of the one-on-one communication exchange between therapist and patient and is a demanding setting as time and financial pressures challenge the communication that physiotherapists are able to achieve with their patients [34].

The participants for this research were nine physiotherapists, in conjunction with their patients (see Table 1 for details about physiotherapists). Patient participants comprised 15 males and 37 females, aged between 20 and 70 years. Reasons for seeking treatment were: spinal pain (25), work-related injuries (4), knee pain (6), sports injuries (4), other peripheral pain (4), balance and neurological conditions (5), women's health concerns (3) and chest treatment (1). These conditions are typical of the presenting complaints in a 20-30 minute private practice treatment encounter.

Each observed consultation was audio-recorded with field notes taken contemporaneously. Initial and follow-up consultations ranging from twenty minutes to an hour were observed, with most sessions being 30 minutes in length. Nine semi-structured interviews with physiotherapist participants and

nine semi-structured interviews with patient participants were also audio-recorded. While this paper focuses on identifying physiotherapists' communication through observation and examining their understanding and interpretation of their communication through interviews, patients' views are also highly relevant to developing an empirically based overview of this type of clinical communication and will be reported in a subsequent paper. Physiotherapist participant interviews focussed on the physiotherapists' perceptions of their own communication approach and their consideration of communication models, adding detail to the results generated from the observations.

Data were analysed using thematic analysis informed by the constant comparative method described by Charmaz [37]. This iterative process involved cycling between the three data sources of observational treatment session transcripts, field notes and interview transcripts. Analysis was also driven by a theoretical interest in models of healthcare communication [38]. The first step involved repeated listening to audio-recordings and collation of all textual data as data immersion. All interview and significant sections of observational data were transcribed verbatim and combined with field notes. Data were then coded into descriptive categories of the communication content and style. These categories were further collated and developed into communication themes with links made between each of the themes to further refine them, as per Braun and Clarke's description [38]. Several guiding questions assisted in collating categories and developing themes that included: what did the physiotherapist focus on when communicating with this patient?; what communication process was apparent?; who led the communication?; and, for the interview data, how does the physiotherapist describe their communication? Themes were then compared with features of models of healthcare communication referred to in the introduction. Data collection continued until no further themes were generated during the analysis, that is, until saturation was achieved [39].

The research was undertaken with ethical approval from the University's Human Ethics Sub-Committee, ethics ID: 1238974. All participants were informed about the research with a plain language statement and provided written and verbal consent prior to participation. All names used here are pseudonyms.

3. Results

The results are divided into observational and interview based data. Five themes emerged from the observational data: a focus on physical aspects and pain, structured communication, leading the communication, casual conversation and touch as communication. The key interview based theme is a sense of purpose.

3.1 *Observational themes*

3.1.1 *A focus on physical aspects and pain*

Overwhelmingly, the content of observed patient-physiotherapist interactions focussed on physical aspects of the patient's concerns, particularly the details and location of pain. This focus was generated from a physiotherapist perspective, with physiotherapists using very specific questions and terminology. Talk centred around physical activity restrictions or limitations, details of pain and other physical symptoms such as pins and needles or weakness.

Tommy (physiotherapist): (chuckles) Yeah, you need to use your muscles more. So that is why I'll have a look at to see whether it's your pain limiting your muscle function today or whether we can do some strengthening exercises for your neck muscles

Dan (patient): Sure

Tommy: Okay and you know the last time I mentioned about you, um, checking whether you have any of those symptoms like um double vision, dizziness, saliva in your mouth, um difficulty speaking, difficulty swallowing... any of those symptoms come on?

Dan: I didn't have any of those.

Sharon (physiotherapist): Does that feel comfortable?

Robert (patient): Yeah that's alright.

Sharon: No pain?

Robert: A little bit, not much.

Sharon: On a scale of zero to ten, how painful is that?

Education provided was generally presented in a scientific, anatomical manner with physiotherapists frequently drawing diagrams or using wall charts to explain parts of the body and influences on movement and pain.

3.1.2 A consistent structure

All interactions observed conformed to a repeatable and consistent overall structure. The physiotherapist directed this structure. First there was a brief greeting followed by some questions asked by the physiotherapist of the patient. Next the patient was asked to perform certain movements and then to relax while they were moved by the physiotherapist. Following this, there was discussion and often 'hands on' or manual treatment before a conclusion involving exercises and advice. Most sessions ended with prompt, professional direction from the physiotherapist as illustrated in the transcript below.

Kate (physiotherapist): So, we'll leave it at that, ideally we'll catch up in about a week's time I think

Clarissa (patient): Okay

Kate: And ah, we'll go from there... O-kay.

Clarissa: Thank you

Kate: No worries. Come out when you're ready.

3.1.3 Physiotherapists lead the communication

Donna (physiotherapist): Today what I want to do is I want to do some more balance tests because we haven't finished the whole thing. Generally what I do is, um, I start assessing you and give you something to go away with, some treatment, give you an exercise and then we sort of finish the tests and I get sort of give a more of a rounder fuller picture, otherwise you're here for an hour and a half and it's probably too much. So... can I ask you please to remove your shoes.

As per Donna's instructions to her patient, many features of the observed interactions support a claim that communication was led and driven by the physiotherapist. In association with the structure of the interaction being determined by the physiotherapist and their specific plan and agenda for the

session, physiotherapists were observed to talk considerably more and with a louder voice than the patient with whom they were communicating.

Conversation and question asking was almost exclusively initiated by the physiotherapist. In many observed sessions, the patient did not initiate conversation or ask a question at all. Physiotherapists were mostly instructing and guiding using frequent closed questions. When open questions were used, it was not uncommon for the physiotherapist to follow up with closed questions. James asked his patient about back pain:

James (physiotherapist): You said that it has improved, so what aspects have improved? Has it been the mornings have been better? Or when you get out of a chair?

There were many examples of physiotherapists interrupting the patient's conversation to ask their next question.

Simone (physiotherapist): Mmm, usually the heat does quite well
Margaret (patient): Yeah... I dunno. It didn't really do much// for me pain wise (muffled)
Simone: //Right. Have you been doing any stretches that we have gone through the last time?

The physiotherapist also dominated decision-making by outlining the goals for the patient who passively agreed. There were limited examples of patients engaging in decision-making processes in the interactions observed.

James (physiotherapist): So your goals for me mainly are, is to, maybe add another day of walking
Simon (patient): Yeah
James: Continue doing the exercises
Simon: Yeah
James: Um,... and.. yeah and we'll touch base in the new year and see how your, your back is feeling then. And I also want you to keep an eye on how the mornings are going
Simon: Yeah.

3.1.4 *Use of casual conversation*

This theme arose from the many examples of physiotherapists gently disrupting the structure and focus on physical aspects with social discourse. This took the form of 'friendly' casual conversation, with content centring on social aspects of both the patient's and physiotherapist's lives. Topics such as children, football, nights out, work pressures and food were included. Social talk was more relaxed and appeared as though it brought a transition from focussed physiotherapy mode to friendly mode with both patient and physiotherapist appearing comfortable. Periods of 'friendly' conversation often occurred during hands on treatment or occasionally at a spontaneous moment. The physiotherapists did, however, direct this social interaction back to their planned agenda quickly and effortlessly.

Physiotherapist participant Kate demonstrates this casual conversation, followed by a prompt redirection back to the agenda of the session.

Kate (physiotherapist): Okay. Let's get you to take your shoes and top off

Serena (patient): Yep (Serena took her top off down to bra very comfortably)

Kate: And get you to have a sit up on here. One of our paediatric physios has been here over the weekend

Serena: Oh cute

Kate: So we've got Molly the Dolly (stuck on the mirror)

Serena: (laughs)

Kate: I'll get rid of you, hey? (peeling off the sticker from the mirror) Now, have a seat on the edge of the bed. Okay. So have you got any pain at the moment?

3.1.5 *Touch as communication*

Touch was an important theme arising from the data. Communication through touch occurred in conjunction with extensive use of other non-verbal communication skills such as gestures, head nodding and eye contact. These non-verbal elements from the physiotherapist appeared to be aimed at demonstrating empathy, engagement and interest in the patient as an individual person. For example, physiotherapists were frequently observed to convey care

and understanding through a pat or stroke on a patient's leg or upper arm when the patient showed signs of being upset or in pain. These moments broke up the specific therapeutic agenda and purpose of the treatment session, demonstrating genuine care for each individual patient.

Whether or not the physiotherapist was conscious of it, the communication through touch occurred spontaneously and instinctively in response to the patient. Field notes commented:

This physiotherapist has very strong awareness through her hands. A sensitivity to the individual patient that conveys consideration and respect is achieved through the manner that touch is employed in the interaction. (Encounter 2, physiotherapist Kate)

In addition to spontaneous and caring touch, therapeutic touch itself was adaptive and responsive and worked as a communicative tool. Further field notes commented:

She places her palms and fingers broadly on the patient's body before settling on where she wants to palpate. The palpation is sensitive yet firm and purposeful. She asks the patient to verify her feelings (what she feels through her hands) occasionally. Once she settles on a specific treatment then the touch becomes very rhythmic, it is relaxing, consistent and provides a connection between the two interacting. (Encounter 3, physiotherapist Kate)

3.2 Physiotherapist interview theme

3.2.1 A sense of purpose

A capacity for physiotherapists to describe their own purposeful style of communication was a strong theme in the interview data. Each physiotherapist provided their perception of their communicative role and each had a slightly different emphasis that was also evident in the observations. For example, in her interview, Donna explained how she recognised patients' differences and purposefully changed her communication depending on each patient's personality, temperament and learning style:

In terms of style, communication style, it really does depend on their temperament, ... and their learning style too, so adults learn in different ways.

Physiotherapists talked about the values and sentiments that they seek to convey to their patients, including empathy, respect and achieving rapport.

Caroline: I think my model is to ah, be empathetic, um, but to be friendly and engaging and um, yeah and I think also to, I mean I think they're the main things, to be friendly, engaging, open and empathy... I think empathy is a really big one to meet them at their story is really important.

Physiotherapists described the specific content of their interactions with patients incorporating biomedical aspects, psychosocial aspects, pain and disability. They also talked about a focus on specific skills such as physical skills or manual therapy, knowledge, education and learning as being important to their communication with patients.

Donna: Rehabilitation is my aim.... So education is a big part of what I do.

Tommy: Skills and technical is a big role and how you reason it plays a big role.

When asked whether they utilised models, styles or theories to direct, guide or inform their communication with patients, physiotherapists did not volunteer models or approaches. For example, physiotherapist participant, Sharon, stated:

I wouldn't know models as you're asking me. No, not specifically like that.

Caroline: I don't really know the models, so...yeah.

James: ... I can't think of the people or the theories. But I got a bit, I got a bit of stuff out of that originally, but then I think it's also the, as a, I don't think I've read a lot about it, I think it's more so um, me as a person.

Instead, physiotherapists proposed their own communication ideals to demonstrate the purposeful nature of their communication.

4. Discussion and Conclusion

4.1 Discussion

The two goals of this research were to examine whether and how established models of healthcare communication are incorporated into one-on-one consultations between physiotherapists and their patients, and also to consider how such communication is understood and practically translated by therapists in a specific practice setting. The results demonstrate that there is not complete alignment with one model of communication. Many features of physiotherapy communication closely followed aspects of a practitioner-centred model. Namely, the content of the communicative interactions focused on physical and biomedical aspects of the patient's condition, interactions were structured, and the physiotherapist directed the conversation agenda. More specific categories within these features such as the use of closed questions, and physiotherapists making decisions are also indicative of practitioner-centred communication. These findings align with previous research demonstrating practitioner-centred, biomedical features of patient-physiotherapist communication in various settings [32, 33, 40].

This structured and practitioner controlled approach was however, moderated by a responsive style of communication. Physiotherapists attended to their patients' needs through caring and communicative touch and they used casual conversation and friendly banter to break up the biomedical focus. These features are representative of a patient-centred style of communication. Touch has previously been acknowledged as a vital component of physiotherapy practice, frequently utilised for communication with patients [41-43]. Roger and colleagues described a form of caring touch, displaying empathy and support, as well as touch used to build rapport or to reassure the patient in the inpatient setting [42]. These ideas resonate throughout our data. Touch is a notable component of communication in physiotherapy, particularly as a means of building relationships with patients and attending to them as individuals.

In this research, casual conversation, or 'rapport building' was another feature that linked to patient-centred communication as it was purposively used to respond to the interests and needs of the individual patient [44]. Non-medical conversation was similarly identified in an analysis of pharmacist-patient

communication [45], where it was considered an important element of relationship building, encouraging active patient involvement and achieving trust between practitioner and patient [45]. These elements are highly relevant to the private practice physiotherapy encounter where active involvement of the patient is required to achieve the goals of practice [26]

While each physiotherapist described a clear focus and purpose for their communication with patients, they did not link these purposes with explicit models of communication. This finding suggests that physiotherapists are not consciously utilising models to support their communicative practice.

4.1.1 Research limitations

Qualitative research, being inductive and hypothesis generating, has strengths and weaknesses. An inability to quantify the results is offset by the ability to generate new theory. The aim of this research was to be exploratory and therefore further study is required to validate the findings. Measuring and quantifying patient-centred elements within the observations through a system such as the Roter interaction analysis system (RIAS) [46] would provide more comparative data and therefore expand knowledge of physiotherapy communication. We propose that this type of quantification of the themes and communication techniques highlighted in this research be undertaken in the future.

Incorporating only two private practices in a specific geographical location (Metropolitan Melbourne) is a limitation to the transferability of this research's results. Nevertheless, the results do align in part with previous studies proposing that physiotherapists are incorporating practitioner-centred, biomedical aspects into their communicative practice with patients. In addition, one author (AH) undertook the complete data analysis, impacting upon the rigour of the research. This was addressed in part through consultation with the second and third authors who independently analysed some transcripts prior to group discussions where consensus was reached regarding interpretation of the data collected. It is also recognised that this manuscript only reports the observational and physiotherapist perspective of communication. To gain a complete picture of the interaction, patient perspectives are also required. The

patient perspective was also obtained as part of this research project and will be reported in a future paper.

4.2 Conclusion

In the private practice setting observed communication was structured, focussed on physical aspects and led by the physiotherapist, these features represented a predominantly practitioner-centred approach to communication. Additionally, aspects of patient-centred communication and empathy were evident through touch and the use of casual conversation. Therefore, the communication occurring in the time-limited private practice physiotherapy treatment encounter is predominantly representative of a practitioner-centred model of communication punctuated by the subtle use of touch and casual conversation to implicitly communicate competence and care. However, physiotherapists did not explicitly draw from theories of communication to inform their practice, relying instead on their own experience and intuitive assessment of patients' needs.

4.3 Practice implications

To ensure that clinical communication is an evidence based aspect of physiotherapy practice, this research highlights a need to articulate physiotherapy specific elements of communication. Achieving effective communication skills training requires detailed empirical evidence of communication in practice [47]. Outlining elements of communication would raise awareness of their use in clinical practice and their connections with communication theories. Currently, the use of touch and casual conversation are significant elements of patient-centred communication in physiotherapy that appear purposeful, yet are implicit. Further research to theorise physiotherapy-based clinical communication may help in progressing education to be related to explicit and empirically based communicative aspects of practice. In addition, understanding theories of communicative practice developed from empirical research should enhance professional self-awareness, which is a fundamental element of patient-centred care [15].

Conflict of interest

The authors have no conflicts of interest to declare.

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Table 1: Characteristics of physiotherapist participants

Pseudonym name (gender)	Years of practice since graduation	Postgraduate study/qualifications	Number of consultations observed (initial/follow-up)
Sharon (female)	3.5	Clinical Masters (Musculoskeletal)	7 (2/5)
Tommy (male)	8	Clinical Masters (Musculoskeletal) Clinical Masters (Sports) Clinical Doctorate	7 (2/5)
Simone (female)	8		6 (1/5)
Kate (female)	21	Clinical Masters (Musculoskeletal) PhD	7 (1/6)
Clint (male)	20	Clinical Masters (Neurological) PhD candidate	5 (1/4)
Lachlan (male)	1.5		7 (1/6)
James (male)	5	Postgraduate Certificate (Sports)	7 (1/6)
Donna (female)	19	Postgraduate Certificate (Continence and pelvic floor)	7 (3/4)
Caroline (female)	20	Postgraduate Certificate (Continence and pelvic floor)	0

Appendix B: Publication in Qualitative Research Journal

(Author accepted manuscript)

Reflexivity and the clinician-researcher: managing participant misconceptions

Amy J Hiller and Danya F Vears * joint first authorship

Structured Abstract

Purpose: It is increasingly common for health care clinicians to undertake qualitative research investigating an aspect of their own profession. Although the additional knowledge and perspective of a clinician might benefit the research, the professional background of the clinician-researcher can be a precipitator for confusion, similar to the therapeutic misconception occurring in quantitative clinical trials research. A significant challenge for the clinician-researcher is managing the misconceptions of participants and others about their role in the research process. The purpose of this paper is to outline these misconceptions and provide insight into how they might be avoided and managed through awareness and reflexivity.

Design/methodology/approach: In this paper we draw on our experiences as clinician-researchers and memo writing data from our respective qualitative research projects to discuss participant misconceptions. Theories of reflexivity and ethics support the discussion.

Findings: Potential misconceptions from participants include feeling obliged to participate, expecting to receive clinical care or feedback and believing they are being judged. This article promotes reflexivity as a tool to pre-empt, prevent and manage participant misconceptions resulting from misunderstandings about the role of the clinician-researcher.

Originality/value: Alerting clinician-researchers to potential misconceptions and providing examples of reflexive thinking in practice can assist researchers to increase the rigor of their qualitative research.

Introduction

It is becoming increasingly common for clinicians to undertake qualitative research investigating their own profession (Asselin, 2003; Fisher, 2011; Hunt et al., 2011). In this article we discuss this specific qualitative research context in which the “dual role” researcher, who is a trained health care professional, explores an aspect of his or her own profession or professional practice (King and Churchill, 2008). Such “insider research”, so termed because the researchers have an inside perspective of the profession they are researching (Asselin, 2003), is recognized as being both potentially advantageous and disadvantageous to the research process (Cumming-Potvin, 2013; Finlay, 2002; McEvoy, 2001). This article discusses the perspectives and perceptions of this “clinician-researcher” who adopts the researcher role while acknowledging prior clinical experience and perspectives as relevant and influential to the research process (McNair et al., 2008).

The authors are qualified health care professionals and qualitative researchers. Danya is a trained genetic counselor currently conducting research investigating Australian practices for genetic carrier testing in children. Her research involves semistructured interviews with genetic health professionals and parents of children with genetic conditions. Amy trained and worked clinically as a physiotherapist prior to commencing research. Her current research is a qualitative exploration of the interaction between patient and physiotherapist in the private practice setting. This research has included observation of treatment sessions and in-depth interviews with both physiotherapist- and patient-participants. Our clinician-researcher experience is used to provide examples and support our argument throughout the article.

Benefits and challenges of research undertaken by a clinician-researcher

Many of the benefits of being an insider and combining clinician and researcher perspectives when researching one’s clinical field relate to the interaction between the clinician-researcher and their participants. The clinical position is likely to improve accessibility to recruiting potential participants, whether they are patients or other health care practitioners (Asselin, 2003; Reed and Procter,

1995). Both patient- and practitioner-participants are more likely to agree to participate when the researcher is known to them, either as a colleague or a clinician (McEvoy, 2001; Richards and Emslie, 2000). In addition, an existing relationship between researcher and participants can reduce the amount of time required to develop rapport, which might increase participants' openness and honesty during the research process (Asselin, 2003; Holloway and Biley, 2011; McConnell-Henry et al., 2009; Wilde, 1992). Rapport is particularly important in the qualitative research context where interviews and focus groups are common methods of data collection. Finally, because of their professional background, clinician-researchers combine motivation and interest with familiarity of the clinical environment and terminology to ensure generation and dissemination of clinically relevant research (Chew-Graham et al., 2002; McEvoy, 2001; Reed and Proctor, 1995; Wilde, 1992).

There are also challenges associated with managing the dual perspective of clinician-researcher. Many such challenges are associated with the differing and occasionally competing goals and obligations associated with the roles of clinician and researcher (Allen, 2004; Asselin, 2003; Colbourne and Sque, 2004). The clinician focuses on providing and maximizing medical benefit to individual patients; the researcher focuses on generating knowledge to benefit patients in the future, keeping in mind that the primary aim of the process is to answer the scientific question (Brody and Miller, 2003; Joffe and Miller, 2008). The goals of these two roles can be viewed as distinct, occasionally referred to as the "difference position" (Brody and Miller, 2003), or overlapping, known as the "similarity position" (Miller and Brody, 2003). Understanding the scope and boundaries of these roles and consciously considering the perspective associated with each is an important component of qualitative research for the clinician-researcher. Failure of the clinician-researcher to achieve this understanding is likely to compromise both the ethical and the methodological rigor of the research.

Comparisons with quantitative clinician-researchers – the therapeutic misconception

In quantitative clinical trials the therapeutic misconception, where "clinical research subjects fail to recognize the ways in which research participation may involve the sacrifice of some degree of personal care", is a significant challenge

for the clinician-researcher (Appelbaum et al., 2004, p. 1). The concern is that patient-participants are likely to confuse their participation in the clinical trial with personalized clinical care. The inability to distinguish between research participation and clinical care is a misconception that is likely to be further compounded if the researcher treats or has previously treated the patient-participant (Glannon, 2006).

There are two main components to the quantitative therapeutic misconception. The first relates to participants' misconceptions about the likelihood that the study will be directly beneficial to them (Appelbaum et al., 2004; Penman et al., 1984). It is well documented that people hope to benefit from research and that this is often what motivates them to participate, even when researchers are explicit about the lack of likely benefit (Glannon, 2006). The second component concerns participants' inability to appreciate that individualization is not possible within the research project (Appelbaum et al., 2004). Participants are often unaware that they are randomly assigned to a specific treatment, and are not being provided with personalized care (Appelbaum et al., 2004).

Participant misconceptions are problematic for two reasons: first, they might inhibit participants' abilities to give free and informed consent to participate (Dresser, 2002); second, they can reduce the methodological rigor of the research, often by influencing the data collected. An inability to give free and informed consent is partially driven by the innate power imbalance between clinicians and their patients where clinicians are viewed as "trusted agents" which confers "legitimacy and secures people's cooperation" (Dixon-Woods and Tarrant, 2009, p. 2221). Therefore, when clinicians adopt the researcher role, issues concerning coercion arise (Townsend et al., 2010). Furthermore, lack of appreciation of how participation in research differs from regular treatment and might impinge on standard care prevents patient-participants from making informed decisions about participation (Miller and Joffe, 2006). Participants might also underestimate the risks associated with participating in clinical research studies (Joffe et al., 2001). To manage these ethical issues, "patients should be informed that the primary goal of research is to gain new knowledge and that participating in a research study may or may not clinically benefit them" (Snyder and Mueller, 2008, p. 24).

Participant misconceptions in the qualitative setting

Although similar participant misconceptions occur in qualitative research involving clinician-researchers, these misconceptions have not been outlined explicitly in the literature. Quantitative and qualitative participant misconceptions differ in three ways. First, participation in qualitative research does not involve the possibility of medical treatment, reducing potential therapeutic benefit from participation. This is likely to affect the motivations and perceptions of patient-participants. Second, qualitative research frequently involves clinicians as participants, adding another group in which misconceptions can occur. Finally, health care professionals and the general public are likely to be less knowledgeable about the nature, purpose and methods of qualitative than quantitative research. Brooks (2007) suggests that the language and terminology used to describe qualitative research is difficult for health professionals to comprehend which might contribute to participants' misconceptions.

We add to the literature by considering the perspective and possible misconceptions of qualitative research participants. We discuss the importance of reflexivity and adaptability in the clinician-researcher to minimize such misconceptions, arguing that reflexivity enables the clinician-researcher to conceptualize and subsequently manage perspectives and perceptions of the roles of clinician and researcher. This process is part of achieving methodologically and ethically rigorous research. Reflexivity is therefore a means to pre-empt and address potential participant misconceptions and is arguably an essential tool for clinician-researchers to maximize research quality.

Reflexivity

Reflexivity is a complex concept commonly associated with the practice of qualitative research. It has been described as “disciplined self-reflection” (Wilkinson, 1988, p. 493) or “thoughtful, conscious self-awareness” (Finlay, 2002, p. 532), with the necessity of thinking highlighted (Doyle, 2013). Most accounts suggest that reflexivity involves researchers reflecting on the research process in a way that demonstrates self-consciousness and consideration of their

role and impact. Therefore, reflexivity involves components of acknowledgement and identification as well as critical evaluation (Underwood et al., 2010). Consistent with previous health care research, this is the definition of reflexivity we adopt here (Alex and Hammarstrom, 2008; Colbourne and Sque, 2004; Finlay, 2002).

Reflexivity is accepted as a way of enhancing research rigor and credibility in qualitative research (Alvesson, 2011; Finlay, 1998; Johnson and Waterfield, 2004). Reflexivity reduces bias by making the role and impact of the researcher transparent. The anticipation and modification of research practices by the reflexive researcher is an important component of qualitative research rigor (Finlay, 2002). In addition, reflexivity has been identified as an instrument to help recognise “ethically important moments,” both when they occur and preemptively (Guillemin and Gillam, 2004, p. 265). The process of reflexivity can provide guidance beyond a principle-based approach to manage ethical moments, suggesting reflexivity has a role in enhancing the ethical aspects of research (Hewitt, 2007; Townsend et al., 2010).

There are limited published examples of how to practise reflexivity (Underwood et al. 2010). Seeking to increase practical understanding of reflexivity, we outline, with examples from our experience as clinician-researchers, the participant misconceptions we have experienced. We subsequently illustrate how reflexivity has assisted us to achieve the awareness necessary to pre-empt and manage these challenges. We discuss issues related to being a qualitative clinician-researcher in three categories: 1) patient-participant misconceptions, 2) practitioner-participant misconceptions, and 3) the influence of the clinician-researcher’s opinion and professionalization.

Potential misconceptions of patient-participants

a) Obligation to participate

A concern for clinician-researchers is that patient-participants might feel obliged or coerced to participate because their treating practitioner is participating or assisting with recruitment (Johnson and Macleod Clark, 2003; McConnell-Henry et al., 2009). This misconception is driven by a power imbalance in the practitioner-patient relationship that can threaten ethical rigor by hindering the

patient-participant's ability to consent to participate freely and voluntarily (Hunt et al., 2011). Consider Danya's reflection:

My study interviewing parents of children with genetic conditions involved recruitment through genetic services and multi-disciplinary clinics at which these children had been treated. One physician from the clinic I anticipated recruiting a large proportion of my participants was also one of my project advisors. Because of my genetic counseling background, I was concerned parents might confuse me for a member of their treating team and feel coerced to participate.

Patient-participants are often recruited through their treating practitioner in qualitative health care research. There is tension between wanting potential participants to agree to be involved in the research and feeling free to refuse participation. This common scenario was complicated by Danya's clinical background and she had valid concerns about how disclosing this to potential participants might inhibit their ability to give voluntary consent. Reflexivity can allow recognition of the potential for coercion. Clinician-researchers can then consider the importance of developing a research design that creates an environment enabling potential patient-participants to refuse participation if they wish.

Danya undertook a number of steps to reduce the potential for coercion. First, an initial introductory letter was sent from a physician and genetic counselor within the treating team with an opt-out form and reply paid envelope. Second, when Danya contacted potential participants to provide additional information she explained she was from the university, and the information statement explained a decision not to participate would not impact on clinical care. Third, Danya decided not to disclose her genetic counseling qualifications to potential parent-participants at least until the conclusion of the interview. These steps reduced concern that the participants would confuse her with the treating team. The application process to the Human Research Ethics Committee assisted with consideration of these points. Despite Danya's clinician-researcher role, these steps decreased the potential for the misconception of obligation to participate.

b) Clinical expectations of patient-participants

As previously mentioned, in quantitative clinical trial research patient-participants can have expectations that participation will provide them with clinical care, viewing the interaction with the clinician-researcher as therapeutic rather than investigative (Colbourne and Sque, 2004; Holloway and Wheeler, 2002; McConnell-Henry et al., 2009). Likewise in qualitative research, patient-participants can misunderstand what participation involves and think that the clinician-researcher will provide information, advice or education as part of the research process (Richards and Emslie, 2000). Consider Amy's example from her research memos:

While conducting interviews following observations of physiotherapy sessions, some patient-participants asked me questions about their treatment, requested information or wanted reassurance about their management. During one interview, a patient-participant asked whether a particular recovery period from surgery was normal and if the exercises prescribed were appropriate. I wanted to answer from my clinical knowledge but felt uncertain how to react. I refrained from disclosing my experience or clinical expertise. I remained honest in a minimalist way, gently suggesting she could ask her treating clinician for more details.

The patient-participant in this example confused the role of the researcher with that of a treating physiotherapist. For clinician-researchers there is a tension between obligations as health care professionals to provide health information and attempts to focus on the researcher role. Some clinician-researchers have identified and emphasized the natural desire to launch into the role of clinician and respond to the queries of the patient-participant, especially during the interview process (Fisher, 2011; Colbourne and Sque, 2004). However, rigorous research requires striving to minimize impact on the clinical interaction and outcome and an appreciation of the differences between research and clinical practice, for example, clinical and research interviewing (Hunt et al., 2011). There are differing views about whether adopting a clinical role and responding to the patient-participant as a clinician, particularly during the interview data collection process, is appropriate. This can have methodological implications and might "contaminate" the data; alternatively it can increase rapport resulting in rich, detailed data. Amy's physiotherapy example highlights that providing patient-participants with treatment information could impact on the relationship between the patient-participants and their treating clinician. It might also

disrupt the trust the researcher had established with the clinicians assisting with participant recruitment. All of these expectations of patient-participants have possible methodological and ethical implications and require careful consideration.

Being reflexive allows recognition and management of these tensions when they occur. Amy's notes reiterate this point:

While observing one patient-physiotherapist interaction, I suddenly realized that I was not aware of the patient's diagnosis and treatment plan. This provided me with a real sense of achievement because it had been a constant struggle to suppress the clinical part of my brain and focus on the research elements, in my case, the communicative aspects.

Being reflexive prompts consideration of managing clinical expectations both during patient-participant recruitment and data collection. It is important to contemplate ways of informing patient-participants about the research that reduces the likelihood that they will confuse the research with their clinical care. Considerations include who introduces and explains the research, and whether this should be someone separate from the patient-participant's treatment provider. Reducing patient-participant expectations for receiving care and appropriately informing them about the goals of the study should lead to reduced misconceptions and ethically appropriate informed consent.

c) Confidentiality concerns

Patient-participants might believe the research is being conducted by the health service, clinical practice or another participating organization, as opposed to a separate research group or university. Subsequently, patient-participants can become wary about the confidentiality of their participation, especially in interviews or focus groups. Although potentially problematic for any researcher within the clinical setting, confusion is likely to be enhanced if the patient-participants know the researcher has a clinical background. For example, we were both concerned patient-participants might not understand the research was being undertaken through the university, rather than by the physiotherapy practices or genetic services. We wanted participants to be confident the

information they were sharing in the interviews was confidential and that members of their treating team would not have access to the transcripts.

Being reflexive early in the research design phase was integral to identifying and managing these misconceptions. Danya carefully outlined in the initial letters of invitation to the patient-participants from the genetics services that the research was being conducted through the university with the genetic service just assisting with recruitment. Again, choosing not to disclose her genetic counseling qualifications to the patient-participants helped separate her from members of the genetics services undertaking recruitment and encouraged uninhibited discussion of the processes that had taken place during genetic consultations. Additionally, Danya stated in her recruitment telephone call that participant and family names would be de-identified, with names of the hospital and members of their treating team removed from transcripts. This was reiterated during the verbal consent process prior to the audio-recording of each interview.

Similarly, Amy specifically explained the distinctions between herself as a university researcher and the physiotherapy team to patient-participants. This made a considerable difference to patient-participant openness and honesty with patient-participants willingly sharing their experiences and naming health care professionals involved in their treatment, knowing that the information was confidential and separate from their clinical care. We believe these distinctions also helped patient-participants feel able to refuse participation.

Potential misconceptions of practitioner-participants

a) Expectations of receiving feedback

Practitioner-participants often have expectations that the clinician-researcher will provide feedback or advice about an aspect of clinical practice. Asselin (2003) describes the frequent misconception that staff development researchers are regarded as educators, rather than researchers. The challenge for the clinician-researcher is twofold: first, the need to be aware of this misconception and second, to carefully consider how it can be appropriately managed. In our experience, practitioner-participants frequently requested feedback. Amy stated in her research memo:

My physiotherapist-participants knew I was also a physiotherapist, and even during the recruitment process, asked if I could provide feedback on their practice following my observations. The physiotherapist-participants also frequently asked my clinical opinion about particular patients that I had observed in their consultations while collecting data.

It is understandable that practitioner-participants appreciate feedback on their practice and view the clinician-researcher as an expert due to the researcher role (Chew-Graham et al., 2002). Moreover, practitioner-participants might have expectations for feedback based on their willingness to participate in a research study, a misconception about the outcome of participation that requires careful consideration and management. Providing feedback could impact considerably on the data collection phase as the clinician-researcher directs their concentration and focus away from the research process itself, subsequently detracting from the quality of data collected.

The portrayal of self and management of both clinician and researcher roles are key aspects to reducing the expectation for feedback by practitioner-participants. It is evident that if clinician-researchers do not disclose their clinical background, requests for feedback are unlikely to occur. Authors have discussed the difficulties associated with knowing whether to disclose one's clinical background and the importance of achieving a balance between the two roles (Colbourne and Sque, 2004; Richards and Emslie, 2000). Some advocate for disclosure, but with considerable emphasis on the researcher role (Colbourne and Sque, 2004). Disclosure allows the researcher to be honest, subsequently improving the participant-researcher relationship (Chesney, 2001; Wilde, 1992).

With considerable deliberation, Amy decided to introduce herself to the patient- and practitioner-participants as both a clinician and a researcher to assist with the recruitment process. Amy then faced the challenge of deciding how to appropriately manage potential requests for feedback. Thinking reflexively and considering different perspectives, she decided it was imperative the physiotherapist-participants understood she was acting in a research capacity and she deliberately explained this to them, adapting her behavior to disengage from the clinical aspects of practice. In addition, Amy offered to provide staff with an education and feedback session at the study conclusion. Rather than risking reducing the quality of data collected by giving individual feedback,

providing an overall education session after completion of the research ensured the information they received was clinically relevant without detracting from the research process.

b) Perception of being judged

As practitioner-participants are often uncertain about the nature or purpose of the research, they may feel that they or their clinical practice are being judged, leading to the potential for practitioner-participants to mistrust the clinician-researcher (Chew-Graham et al., 2002). Such mistrust could be related to suspected hidden agendas for undertaking or participating in research (McConnell-Henry et al., 2009). Mistrust or uncertainty might also be associated with a lack of understanding about qualitative methodologies. Amy reflected in her memos:

Many clinicians commented in their interviews that my presence during the sessions I observed made them want to do everything “correctly” meaning they spent more time assessing and reassessing aspects of the patient’s presentation than usual. Interviews with patients also confirmed that the practitioners seemed to do more “tests” when I was present. This occurred despite my clear and repeated explanations that I was undertaking exploratory research, there is no right or wrong way, and my interest was solely in the communicative rather than clinical aspects of the patient-physiotherapist interaction.

Amy spent considerable time deciding whether to video-record or observe the treatment sessions herself, aware of the impact of these mediums on the interaction. She emphasised the exploratory and non-judgemental nature of the research and was conscious to maintain a relaxed and interested demeanour at all times, rather than a critical presence. Despite her best attempts, her interviews suggested misconceptions of the practitioner-participants persisted, impacting on the overall results of the study. Although the reality of qualitative research is that researcher’s presence impacts on the research (Cohen and Crabtree, 2008), the mindful clinician-researcher can take appropriate steps to minimize the potential misconception of being judged, including providing thorough information for participants and adjusting demeanour to limit judgement assumptions from practitioner-participants.

c) Misinterpretation of the importance of the research results

The final misconception of practitioner-participants refers to the level of importance that practitioners place on the results due to the fact that the researcher is a clinician. This is likely to depend on the clinician-researcher's status within the profession, and can relate to general members of the profession as well as practitioner-participants and is most evident during the dissemination phase of the research:

When writing my introductory biography for a genetic health conference presentation, I included my Master of Genetic Counseling degree and also mentioned it in my presentation. I considered that although I did not want to oversell my experience, this might give my research more credibility with an audience of geneticists and genetic counselors.

Danya utilized reflexivity to consider how to present her results and to recognize that how she introduced herself might impact on the credibility her findings were given by the audience. We advocate that being transparent, understanding the roles of clinician and researcher, and portraying ourselves appropriately will assist to minimize misconceptions of both the practitioner-participants and the profession overall. If the clinician-researcher is measured and perceptive and avoids overstating the findings or inflating the importance of the research, the professional body and individual practitioner-participants should have a clear perception of the research.

The influence of the researcher's opinion and professionalization

In the introduction we highlighted that a clinical perspective can generate research interest, increase research relevance, and improve the likelihood of dissemination of results. However, clinician-researchers need to be appropriate in their research interest and balanced in their approach. In particular, they must ensure they do not have a vested interest in the research outcomes. Consider Amy's reflection:

I commenced this research because I felt the communicative aspects of physiotherapy practice were important and under represented in physiotherapy education. Yet I have always been mindful of not trying to 'prove' a specific idea and have endeavoured to undertake an exploratory research project where I am open to possibilities within the data and results.

Holding preconceived desires for the research findings is not always a conscious or deliberate act. Often this kind of bias is driven by professionalization: professional background can make it difficult to challenge inherent beliefs and recognize specific aspects of the profession's practice. Professionalization influences the predisposition to have certain beliefs about the outcomes of the research which can particularly impact on the data collection and analysis phases of a research project (Colbourne and Sque, 2004). To counter this it is important to be reflexive and consciously consider preconceived ideas.

When conducting qualitative interviews the clinician-researcher is the research tool and therefore personal biases will influence the data collected. The qualitative interviewing style can be challenging for clinician-researchers, and a level of insight is necessary to shift the focus to exploring the experiences of the participant rather than a clinical encounter (Fisher, 2011; Hunt et al., 2011). Professionalization can lead to lapses in objectivity, and authors stress the importance of adopting some level of distance in the research setting (Chesney, 2001; Hammersley and Atkinson, 1983; Holloway and Biley, 2011). Clinician-researchers not aware of the impact their training and experiences have on the conceptualization of their research might make assumptions about what participants are attempting to articulate (Fisher, 2011). Professionalization can also inhibit the level of inquisitiveness and critical thinking achieved by the clinician-researcher during the interview, consequently determining those aspects of the participants' experiences that are or are not explored (Chew-Graham et al., 2002).

We have employed reflexive thinking to identify aspects of our research potentially influenced by our own professionalization. Amy recognized her professional opinion might influence her research and through this mindfulness, has minimized its impact on data collection and analysis. Writing field notes about emotional reactions to particular participants, interviews or observations

can assist in identifying professional biases (Fisher, 2011). Being reflexive about data analysis and interpretation is also important. Discussing interviews and field notes with colleagues who have different professional backgrounds can be invaluable in combating the impact of professionalization. These “outsider” researchers question aspects of clinical practice the clinician might take for granted, stimulating reflection, adjustment and contributing to the methodological rigor of the research.

The clinician-researcher being overly critical of clinical practice

Clinician-researchers are often overly critical of practices within their own health care profession, something Danya realized while reflecting in her research memos:

I noticed that during some of my interviews with genetic health professionals I was judging their views and practice. I sometimes disagreed with their responses to parents’ requests for testing or found fault with their overall attitude toward carrier testing in children. Their processes were not wrong as they were operating within the Australian guidelines. Yet my own ideals about the provision of testing, which I had developed through extensive reading of the literature, did not align with their practices.

Reflexivity is important in identifying when clinician-researchers are being overly critical of the professional field and why this critical stance might be assumed. There are potentially two main facets to this problem. First, the evidence based practice movement encourages clinicians to think critically in their clinical practice, translating to being unjustifiably analytical when researching the profession. Second, adopting a researcher role usually stems from a desire to improve practice or implement change. Wanting to contribute something meaningful to the profession, the clinician-researcher could become particularly critical as a means of “proving” the value of the research.

It is important for the clinician-researcher to identify the risk of overly criticizing the profession and utilize reflexivity as a preventative and management tool, considering their interactions with participants, analysis of data, and presentation of results to the professional body. Through reflexive thinking in

the memo above, Danya identified she was judging practitioners harshly because their practices did not correspond with what she believed to be the best model. This realization allowed her to monitor her interactions with practitioner-participants, ensuring she remained neutral during interviews and did not express her agreement or disagreement with their practices. When analyzing and presenting her findings to the professional body she was also careful to ensure that she represented the views of all practitioner-participants equally, rather than focusing on specific perspectives. These steps assisted in achieving balanced and valid results.

Conclusion

Consideration of the clinician-researcher's impact on patient- and practitioner-participants is an important and relatively unexplored facet of qualitative research in the health care context. Quantitative clinical trials' literature discussing the therapeutic misconception has informed our discussion of the qualitative equivalent and our exploration of the impact of various perceptions of clinician-researcher and participants (Appelbaum et al., 2004; Glannon, 2006; Penman et al., 1984). It is by building an appreciation of these nuances that the reflexive process strengthens.

We have advocated strongly for reflexivity, representing how an awareness of the impact of the clinician-researcher's portrayal of his or her role is vital to achieving both rigorous and ethical research. We recognize that one of the main criticisms of reflexivity is that one cannot be fully aware of all assumptions and subjectivities, making reflexivity impossible to achieve (Bishop and Shepherd, 2011; Finlay, 2002). The endeavor toward reflexivity is a fundamental challenge for qualitative researchers and acknowledgement that it is ultimately impossible for the clinician-researcher to achieve complete awareness of every aspect or perspective should not deter this. Sharing experiences and utilizing the perspectives of colleagues with different backgrounds can stimulate an awareness of subjectivities that might otherwise remain uncovered.

In this article we have outlined potential participant misconceptions in qualitative research in the context of a clinician-researcher researching the professional field. We suggested that utilizing reflexivity can assist with managing challenges and avoiding potential participant misconceptions, thereby

enhancing ethical and methodological aspects of qualitative research in health care. By providing examples and discussion of some of the challenges clinician-researchers might face as they conduct qualitative research in their professional field, we hope to increase the transparency of the research process, making reflexivity more accessible and valuable to qualitative researchers. In addition, open discussion about the process and interpretation of reflexivity as a concept is positive for the legitimacy and credibility of qualitative research as a whole.

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Appendix C: Interview plans

Draft interview guide for physiotherapist participants

Opening comments:

- Research introduction and explain aims of project
- Thank the participant for attending the interview
- Regain informed consent verbally
- Re-iterate that the participant can request that the audiotape be stopped and the interview discontinued at any time.

'In this interview I'm going to ask some questions about how you communicate and interact with your patients. There are no right or wrong answers to these questions. Many physiotherapists have different perspectives and that is the point of this research, to understand the various perspectives that physiotherapists may have.'

Questions:

Professional experience

- Please outline your years of experience, and work history. Where and when did you first obtain your physiotherapy qualifications?
- Have you undertaken any post-graduate study?
- What professional development courses have you attended? What types of professional development interest you and why?

Communication

'I'm interested to know what sort of style of communication you tend to use with your patients? Does it change? If it changes, why does it change?'

- What communication techniques do you use with your patients? Can you give an example of good communication with a patient? Bad communication with a patient?
- Think back to the treatment sessions that I observed earlier. Were there any sessions in which you found communication challenging? Why?

- Please describe types of patients you find easy or challenging to communicate with.
- How do you decide which kind of communication methods or strategies to use? For example, with Mr X earlier, what type of communication strategies did you use and why?
- What is the most important part of your communication with a patient? What are you trying to achieve when communicating with your patients?
- What do you think is important to know about the patient? How do you find out about your patient?
- What are you trying to achieve with your communication?
- What do you perceive to be the patient's role in the treatment encounter?

Biopsychosocial factors

- Which assessment findings generally have the most impact on how you treat a patient?
- What impact does a patient's psychology have on the way that you communicate with them?
- What importance do you place on social factors? Why?

Patient-centred factors

- Think back to patient X that you saw earlier, what sort of a relationship were you trying to develop with him/her?
- What information do you think is most important to give to your patients?
- What sort of education did you give to Mr X? Why?
- Who makes the decisions about your treatments?

Treatment session structure/external factors

- Do you have a structure for your treatment sessions? If so, when might this structure alter?
- What is the first thing that you usually ask at the start of your treatment session? What do you want to know initially? Why?
- During your subjective assessment what is the most important information for you to obtain?
- What factors impact on your sessions with your patients?

Models or approaches to communication

- When you trained as a physiotherapist were you taught about particular models, theories, or approaches for communicating with or caring for your patients? Can you reflect on any models that you may have been taught and how they might relate to how you currently interact with your patients?
- Do you think of your interactions with patients as following a particular model or approach?
- Have a look at the diagram, could you write about your 'style' or philosophy of physiotherapy practice on the diagram? If the terms on there don't mean anything to you please feel free to draw or write your own ideas.

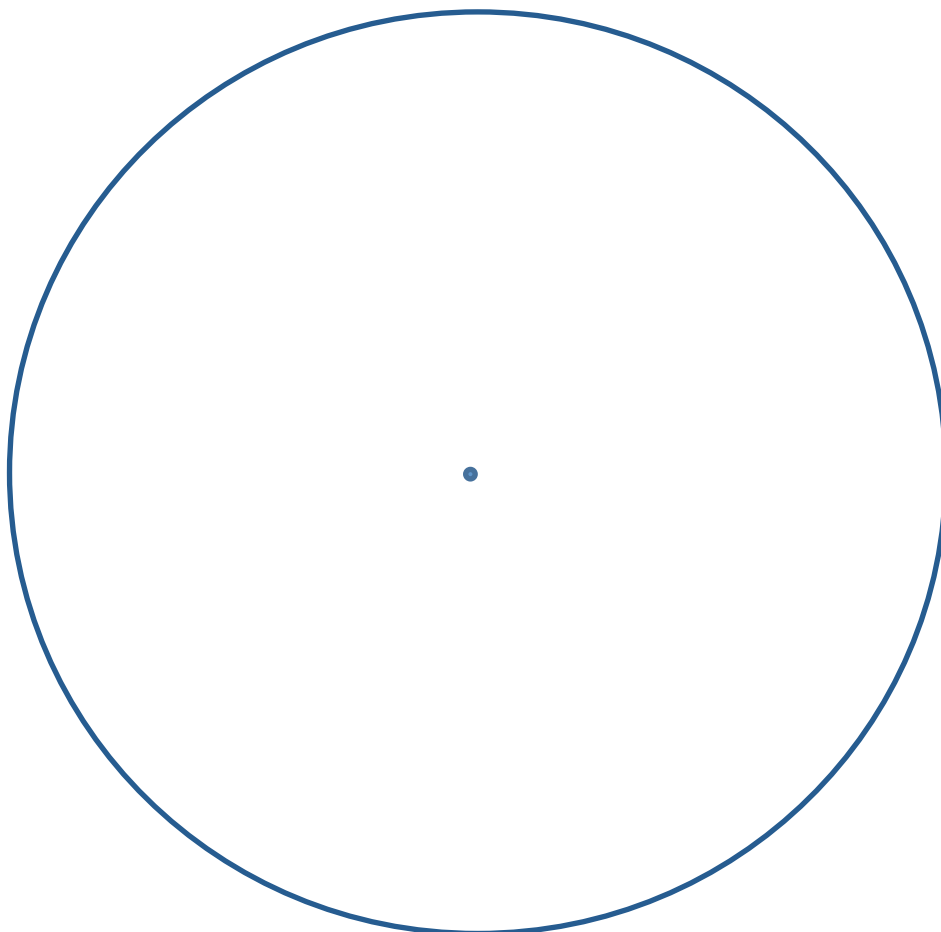
Concluding questions:

- Is there anything we have not discussed that you would like to tell me about?
- Is there anything you would like to bring up, or ask me about, before we finish the interview?

Thank the participant for their time and explain how their contribution will help the research.

Physiotherapist participants

Please place a mark on this spectrum where you feel the focus lies during your treatment sessions:



Consider your approach to interacting with your patients. What do you focus on?
Please add the elements that you consider important to this pie chart.

Draft interview guide for patient participants

Opening comments:

Commence with an introduction, thank the participant for attending the interview, explain the aims of the project, regain informed consent verbally, and reiterate that the participant can request that the audiotape be stopped and interview discontinued at any time.

'In this interview I'm going to ask some questions about how you communicate and interact with your physiotherapist. There are no right or wrong answers to these questions. Many people have different perspectives and this is the point of the research, to understand the different perspectives that patients, such as yourself, may have.'

*Note that I will introduce most of the topics and sometimes describe a possible range of responses as per the sections in italics. This should help the patient to understand the types of things I am interested in hearing about.

Questions:

Background information

- How did you come to be attending physiotherapy for treatment? Did a doctor refer you or did you make an appointment yourself?
- How long have you had the problem that you are seeing the physiotherapist for? How many sessions have you had with the physiotherapist?

Previous experience with healthcare professionals

'I'm really interested in your experience with the physiotherapist and how this might compare to other sessions you have had with healthcare professions'

- Have you seen a physiotherapist before? Have you seen any other healthcare provider? If so, can you describe differences between this

interaction and the interactions you have had with previous physiotherapists or healthcare providers?

- What did you like? What did you not like?

Aspects of communication and patient-physiotherapist relationship

'I'm going to ask you some questions about how you communicated and interacted with the physiotherapist. Some people like to be really friendly with their physiotherapists and others prefer their physiotherapist to just get on with the job'

- What sort of relationship do you prefer with your physiotherapist?
- Do (you think) you have a good relationship? Why or why not?
- Comment on how the physiotherapist understands your problem? What did they do to develop this understanding?
- Did you tell the physiotherapist everything that you wanted to tell them?
- Comment on whether you trust your physiotherapist to help you.
- Who talked the most during the session? Why?
- Was it easy to talk with the physiotherapist? Why or why not?

Biopsychosocial factors

'While most people think of physiotherapy as being about treating physical injuries, physiotherapists are also trained to understand how the injury might be affecting other aspects of your life. I'd like to ask a few questions about these aspects of your treatment'

- Do you feel that the physiotherapist understands how this problem is affecting your life?
- Do you think that your physiotherapist understands your feelings and emotions related to this problem?
- Do you think that it is important that the physiotherapist understands (about your social situation and) the impact of this problem on other aspects of your life?

Goal setting

- Do you know what the goals or aims of your treatment are?
- What is the physiotherapist trying to do? Why?

Decision making

'Another aspect I'm interested in is who makes the decisions about your treatment; the physiotherapist, you or do you decide together?'

- Were there any decisions made about your treatment during the last session?
- Who made these decisions? Did you agree with the decisions?
- What is your role in the treatment process?

Education given

- What sort of information did the physiotherapist give you during the last session?
- Please provide any thoughts about how this information was conveyed.

External factors and structure of the session

- Was there anything that you thought was missing or over-emphasised in the treatment session?
- What was the best part of the treatment session?
- Was there anything else that impacted on the interaction between yourself and the physiotherapist during your session?

Concluding questions:

- Is there anything we have not discussed that you would like to tell me about?
- Is there anything you would like to bring up, or ask me about, before we finish the interview?

Thank the participant for their time and explain how their contribution will help the research

The patient-physiotherapist interaction



Patient participants

Please place a mark on the above diagram where you feel your session with the physiotherapist was located on this spectrum. Also place a mark where you feel it should be located (if different).

Please also draw or write anything else that comes to mind with regard to components of the communication or interaction between yourself and the physiotherapist.

Appendix D: Plain language statements and consent forms

PLAIN LANGUAGE STATEMENT FOR PHYSIOTHERAPIST PARTICIPANTS

Ms Amy Terry (PhD Candidate)

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Email: a.terry@student.unimelb.edu

Associate Professor Clare Delany (Supervisor)

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Research Project:

**“An Examination of how Physiotherapists Interact with their
Patients in the Private Practice Setting”**

Introduction

This research aims to explore how physiotherapists and their patients communicate and interact with each other during treatment sessions. It is known that communication is an important part of the treatment process but there is very little information about how communication is achieved in physiotherapy. While there are many discussed approaches to communication in health care, most of these have been developed for the medical encounter and it is not known how these approaches are used in physiotherapy practice. This research is about documenting and understanding the types of communication and interaction used in physiotherapy practice through observation and interviews. We invite you, as a practicing physiotherapist in private practice, to consider participating in this research project.

What will I be asked to do?

If you agree to participate, I would like to observe and audio-record six to eight of your treatment sessions with patients. You will also be asked to participate in an individual interview with me, which will be audio-recorded with your consent. One or two of your patients, who agree, will also be interviewed at a separate time.

We estimate that the total time commitment for your involvement in the research would be about four hours, three hours of observing your normal practice and an hour interview. Therefore, the only time commitment outside of your normal practice is for an interview that would be undertaken at a time and location convenient for you.

What will be the benefits of participating in the research?

Your participation will not result in a direct benefit to you or your work. Your participation will, however, assist in developing a detailed understanding of the communication strategies that occur in daily private physiotherapy practice. You can discuss your communication style and approach in the interview and may elect to receive a summary document of the key research findings. This experience may provide you with an opportunity for reflection and insight into your own practice.

Are there any risks associated with participating in the research?

It is acknowledged and recognised that there is a chance that you may feel uncomfortable about being observed, audio-recorded and interviewed as described. It is important for you to remember that the research is about exploration and gaining an understanding of what happens in every day

physiotherapy practice. It is not a test of your competence or skill level. If, however, there are any feelings of unease or distress associated with participation in this research you are free to decline or withdraw your participation at any time, even after data has been collected, provided that your data has not yet been processed.

We also acknowledge the importance of debriefing or follow-up to ensure the well being of participants. The researchers encourage questions and will also arrange for a summary of results to be sent to you should you request it on the consent form. Please also note that this research has been granted ethics approval by the University of Melbourne Human Research Ethics Committee and will be conducted under ethical guidelines.

How will my confidentiality be protected?

Your involvement in this research will be as an anonymous participant. A pseudonym will be used rather than your name in any subsequent publications. Your workplace and your individual details will not be used in any discussion of results, data reporting or publications that arise from the research. Your personal details will be stored in a separate, password protected computer file and only utilised by to contact you directly. The transcripts and audio data will be assigned a pseudonym immediately after the data has been collected. All data will be kept on password-protected computers and in locked filing cabinets as per the University of Melbourne's data storage policy. Data will be destroyed after five years. Despite all of these measures, it is important that you understand that there will only be a small number of participants in the study which does increase the possibility that someone may be able to identify you.

Please note that your patient's comments, interpretations and views will also be kept confidential. You will not be able to obtain a copy of your patient's interview data.

How will I receive feedback?

At the completion of the research you will receive a summary document of the key findings from the research should you request this on the consent form. The results will form the basis of Amy's PhD thesis. It is intended that there will also be journal publications utilising this data which can also be provided to you at your request. The results may also be presented at academic conferences.

Will participation prejudice me in any way?

Your participation is completely voluntary. You are free to withdraw your participation and any unprocessed data you have supplied at any stage. Should you wish to withdraw there will be no prejudice expressed towards you.

Where can I get further information?

I welcome any contact from potential participants on the details provided at the top of this statement. Please contact me if you have any questions or concerns. Should you have any queries regarding the conduct of the research project, you are also welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, ph. 8344 2073; fax 9347 6739.

How do I agree to participate?

If, given the above information, you would like to participate, please read and complete the accompanying consent form and return it in the envelope provided.

You will then be contacted by Amy to arrange a day and time to observe your treatment sessions, recruit patient participants and undertake the corresponding interview.

Thank you for your interest.

PLAIN LANGUAGE STATEMENT FOR PATIENT PARTICIPANTS

Ms Amy Terry (PhD Candidate)

Ph. 0434 722 618 (research mobile)

Email: a.terry@student.unimelb.edu.au

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Research Project:

**“An Examination of how Physiotherapists Interact with their
Patients in the Private Practice Setting”**

Introduction

This research aims to explore how physiotherapists and their patients communicate and interact with each other during treatment sessions. It is known that communication is an important part of the treatment process. There have been some studies of how doctors communicate with their patients, but there is very little information about what type of communication a physiotherapist uses and how patients attending physiotherapy understand and respond to the communication in their treatment session. This research is about documenting and understanding the types of communication and interaction used in physiotherapy practice.

This research is being conducted by researchers from the University of Melbourne and does not involve the physiotherapy practice you are attending.

Your physiotherapist has agreed to participate in this project and you are also invited to consider participating.

What will I be asked to do?

Should you agree to participate, your physiotherapy session will be observed by Amy and audio-recorded. If you are interested, after the treatment session you may also be asked to participate in an interview for up to an hour with Amy, at your preferred time and location. The interview will be audio-recorded with your consent. During the interview you would be asked to talk about your experience of the interaction with the physiotherapist.

What will be the benefits of participating in the research?

There are no direct benefits to you from participating in the research. The information that you would provide by being observed and in the interview will, however, provide the patient perspective of the communication and interaction used in daily physiotherapy practice which is important to the research. The research findings could influence knowledge about physiotherapy communication and interactions in the future. Note also that many people find the opportunity to discuss their thoughts and experiences in an interview useful and even enjoyable.

Are there any risks associated with participating in the research?

This research carries minimal risk to participants. Sometimes people find that discussing aspects of their health or treatment may result in feelings of unease or distress. If this were to occur I will discuss options for you to seek support and advice. Remember that you may withdraw from the research at any point and

that your comments during the interview will not be made available to your physiotherapist.

We acknowledge the importance of follow-up to ensure the well-being of participants. Questions are encouraged and we will send you a summary of the research findings should you request them on the consent form. Please also note that this research has been granted ethics approval by the University of Melbourne Human Research Ethics Committee and will be conducted under ethical guidelines.

How will my confidentiality be protected?

Your involvement in this research will be as an anonymous participant. A pseudonym (false name) will be used rather than your name so that your details will not be identifiable in any discussion of results, data reporting or publications that arise from the research. Your personal details will be stored in a separate, password protected computer file and only utilised to contact you directly for components of the research in which you have agreed to participate. All data will be kept on password-protected computers and in locked filing cabinets as per the University of Melbourne's data storage policy. Data will be destroyed after five years. Your physiotherapist will not be provided with any information from your interview.

Despite all of these measures, it is important that you understand that there will only be a small number of participants in the study. Although unlikely, this does increase the possibility that someone may be able to identify you.

How will I receive feedback?

You will receive a summary document of the key findings from the research if you request this on the consent form. The results will form the basis of Amy's PhD thesis. It is intended that there will be journal publications utilising this data that can also be provided to you at your request. The results may also be presented at academic conferences.

Will participation prejudice me in any way?

Your participation in this research is completely voluntary. You are free to withdraw your participation and any unprocessed data you have supplied at any stage. Should you wish to withdraw there will be no prejudice expressed towards you. This research is completely separate to your regular physiotherapy treatment. There is no obligation from your physiotherapist or the practice for you to participate. Should you choose not to participate or to withdraw, your treatment will continue as normal.

Where can I get further information?

We welcome any contact from potential participants via the details provided at the start of this statement. Please feel free to contact us if you have any questions or concerns. Should you have any queries regarding the safe and ethical conduct of the research project, you are also welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, ph. 8344 2073; fax 9347 6739.

How do I agree to participate?

If, given the above information, you would like to participate, please read and complete the accompanying consent form and return it to your physiotherapist in the envelope provided. Arrangements will then be made to observe and audio-record your treatment session. Following this, you may also be contacted to arrange an interview if you provided your details on the consent form.

Thank you for your interest.

Department of Physiotherapy
Melbourne School of Health Sciences
The University of Melbourne

Consent form for persons participating in a research project

Project Title: “An Examination of how Physiotherapists Interact with their Patients in the Private Practice Setting”

Name of physiotherapist participant: _____

Name of investigators: Ms Amy Terry (PhD Candidate), A/Prof Clare Delany, Prof Marilyns Guillemin

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.
2. I understand that after I sign and return this consent form it will be retained by the researcher.
3. I understand that my participation will involve observation and audio-recording of consultations with patients and an interview of approximately one hour which will also be audio-recorded.
4. I agree that the researcher may use the results of my participation as described in the plain language statement.
5. I acknowledge that:
 - (a) The project is for the purpose of research;
 - (b) The possible effects of participating in the interview and being observed in practice have been explained to my satisfaction;
 - (c) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and that I can also withdraw any unprocessed data I have provided;
 - (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
 - (e) I understand that the number of participants in this research is small and that this may increase the chance of identification despite the confidentiality measures in place;
 - (f) I have been informed that with my consent the interview and treatment sessions will be audio-recorded and I understand that audio-records will be securely stored at the University of Melbourne and will be destroyed after five years;
 - (g) My name will be referred to by a pseudonym in any publications or reports arising from the research;
 - (h) A copy of the research findings will be forwarded to me, should I agree to this.

I consent to being observed and audio-recorded during consultations with my patients (Please tick)

Yes No

I consent to participating in an audio-recorded interview

Yes No

I wish to receive a summary document of the key research findings

Yes No

Participant's signature: _____ Date: _____

Investigator's signature: _____ Date: _____

Department of Physiotherapy
Melbourne School of Health Sciences
The University of Melbourne

Consent form for persons participating in a research project

Project Title: “An Examination of how Physiotherapists Interact with their Patients in the Private Practice Setting”

Name of patient participant: _____

Name of investigators: Ms Amy Terry (PhD Candidate), A/Prof Clare Delany, Prof Marilyns Guillemain

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.
2. I understand that after I sign and return this consent form it will be retained by the researcher.
3. I understand that my participation will involve being observed and audio-recorded during a physiotherapy treatment session.
4. I agree that the researcher may use the results as described in the plain language statement.
5. I acknowledge that:
 - (a) The possible effects of participating in the research by being observed and audio-recorded has been explained to my satisfaction;
 - (b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and I am also free to withdraw any unprocessed data I have provided;
 - (c) The project is for the purpose of research;
 - (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
 - (e) I have been informed that with my consent my treatment session will be audio-recorded and I understand that audio-records will be securely stored at the University of Melbourne and will be destroyed after five years;
 - (f) My name will be referred to by a pseudonym in any publications or reports arising from the research;

I consent to my treatment session being observed and audio-recorded (please tick) Yes No

Participant's signature: _____ Date: _____

Investigator's signature: _____ Date: _____

As outlined in the plain language statement the researcher would also like to interview some patient participants about their experience of the interaction with the physiotherapist.

If you are happy for the researcher to contact you about the possibility of participating in an interview, could you please provide your details below:

Name: _____

Contact phone number: _____

Email: _____

Postal Address: _____

Signed: _____

Department of Physiotherapy
Melbourne School of Health Sciences
The University of Melbourne

Consent form for persons participating in a research project

Project Title: “An examination of how physiotherapists Interact with their patients in the private practice setting”

Name of patient participant: _____

Name of investigators: Ms Amy Terry (PhD Candidate), A/Prof Clare Delany, Prof Marilys Guillemain

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.
2. I understand that after I sign and return this consent form it will be retained by the researcher.
3. I understand that my participation will involve being interviewed for up to an hour by the researcher and that the interview will be audio-recorded.
4. I agree that the researcher may use the results as described in the plain language statement.
5. I acknowledge that:
 - (a) The possible effects of participating in the research by being interviewed have been explained to my satisfaction;
 - (b) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and I am also free to withdraw any unprocessed data I have provided;
 - (c) The project is for the purpose of research;
 - (d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
 - (e) I understand that the number of participants in this research is small and that this may increase the chance of identification despite the confidentiality measures in place;
 - (f) I have been informed that with my consent the interview will be audio-recorded and I understand that audio-records will be securely stored at the University of Melbourne and will be destroyed after five years;
 - (g) My name will be referred to by a pseudonym in any publications or reports arising from the research;
 - (h) I have been informed that a copy of the research findings will be forwarded to me, should I agree to this.

I consent to participating in an audio-recorded interview (please tick)

Yes No

I wish to receive a summary document of the key research findings

Yes No

(Please add your address to send the key research findings should you wish to receive them)

Participant's signature: _____ Date: _____

Investigator's signature: _____ Date: _____

Contact address

Appendix E: Information for recruiters of patient participants

Research description to read to potential patient participants

This information is to be delivered by the practice administrative staff to any patient who makes an appointment to see the physiotherapist participant on the day of the research. To be informed, patients must be over eighteen and understand enough English to read and sign the consent form. Once there are six to eight confirmed patient participants no more patients need to be given this information.

New patients

(those who ring and make an initial appointment with the physiotherapist on the day the observation research will be conducted):

- There will be a researcher from the University of Melbourne here in the physiotherapy practice on the day that you have made your appointment.
- The researcher will be observing some treatment sessions with the physiotherapist that you have made an appointment with on that day.
- The research is about how physiotherapists and their patients communicate and interact with each other during treatment sessions.
- You are under no obligation to participate, but if you are interested could you please arrive 10 minutes early to your appointment so that I can give you some further information about the research.
- If you would like to participate after reading this further information there will be a consent form to sign prior to your treatment session.
- Do you have any further questions at this stage?
- I can provide you with the researcher's phone number if you'd like to contact her with any questions. (Ph. 0434 722 618)
- Thank you for your time and interest.

Follow-up patients

(those who book a follow-up appointment with the physiotherapist on the day the observation research will be conducted):

- There will be a researcher from the University of Melbourne here in the practice on the day of your next appointment.
- The researcher will be observing some of your physiotherapist's treatment sessions on that day.
- The research is on how physiotherapists and their patients communicate and interact with each other during treatment sessions.
- You are under no obligation to participate but if you are interested I can provide you with further information about the research and what it will involve (give them the plain language statement and the consent form).
- Please read through this and if you would like to participate sign the consent form and return it in the envelope to me now or on the day of your treatment session.
- The researcher appreciates your interest and time.
- If you have any further questions please call the researcher (Amy) on 0434 722 618.

Appendix F: Assessment form for University of Melbourne Master of Physiotherapy students

The University of Melbourne

Master of Physiotherapy (Musculoskeletal Physiotherapy)

Student's name _____	
Placement: _____ Dates: _____	
Subjective examination Conducts appropriate assessment with consideration of biopsychosocial factors that influence health Generates and tests diagnostic hypotheses identifying priorities and urgency of further assessment and intervention Responds appropriately to important patient cues (incl. gender, age, culture) Gains informed consent	
Physical examination Structures systematic, safe and goal oriented assessment process accommodating any limitation imposed by the patient's health status Demonstrates sensitive and appropriate handling during assessment process Obtains qualitative and quantitative data relevant to patient's history Modifies assessment in response to patient profile, feedback and relevant findings Applies all test measurements safely, accurately and consistently Respects patient's need for privacy and modesty	

<p>Clinical Reasoning</p> <p>Identifies patient's goals and expectations</p> <p>Selects appropriate tests/outcome measures of each variable for the purpose of diagnosis, monitoring and outcome evaluation</p> <p>Links outcome variables with treatment and management goals</p> <p>Demonstrates ability to put together the findings from the S/E and P/E and make justifiable decisions regarding management</p>	
<p>Planning and action</p> <p>Develops a management plan with both short and long term goals that is relevant to the patient's problems</p> <p>Selects and prioritizes appropriate forms of intervention based on examination findings, theoretical knowledge and evidenced based physiotherapy practice</p> <p>Applies treatment proficiently and effectively and monitors patient's response</p> <p>Establishes appropriate goals and education</p> <p>Identifies factors that may compromise treatment outcomes</p> <p>Considers recurrence/prevention</p>	

<p>Safety</p> <p>Works in a manner that demonstrates knowledge of risk management</p> <p>Communication</p> <p>Provides clear instructions and listens carefully and is sensitive to patient's views</p> <p>Respects cultural and personal differences of others</p> <p>Communicates treatment evaluation process and outcomes to the patient</p> <p>Demonstrates accurate record keeping skills</p> <p>Teamwork</p> <p>Acknowledges expertise and role of other health care professionals and refers/liases as appropriate to access relevant services</p> <p>Collaborates with the health care team and patient to achieve optimal outcomes</p> <p>Time management</p> <p>Completes assessment in acceptable time</p>	
<p>Global rating (Circle as appropriate):</p> <ul style="list-style-type: none"> • <i>Excellent</i> • <i>Very Good</i> • <i>Good</i> • <i>Satisfactory</i> • <i>Borderline</i> • <i>Fail</i> <p>General Comments and recommendations:</p> <p>Signed:</p>	



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Hiller, Amy Joy McGregor

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