The physiotherapy experience in private practice: The patients' perspective

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The aim of this study was to identify the qualities of a 'good' physiotherapist and to ascertain the characteristics of good and bad experiences in private practice physiotherapy from the patients' perspective. The nominal group technique was implemented with separate groups of patients (n = 26) and revealed that communication ability, professional behaviour and organisational ability, and characteristics of the service provided were the main qualities of a 'good' physiotherapist. In particular, communication ability of the physiotherapist was ranked first or second in importance by all groups of patients. Good experiences in physiotherapy were most often attributed to effective communication by the physiotherapist, while bad experiences most often related to dissatisfaction with the service followed by poor physiotherapist communication. Based on the findings from this study, we suggest physiotherapists should actively seek to involve patients in their management. To do this effectively, physiotherapists would benefit from further training in communication skills to ensure that they can successfully adopt a patient-centred approach and to optimise the physiotherapist-patient interaction in private practice physiotherapy. **[Potter M, Gordon S and Hamer P (2003): The physiotherapy experience in private practice: The patients' perspective. *Australian Journal of Physiotherapy* 49: 195-202]**

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Introduction

Patients and practitioners have been found to have differing views of health and to monitor progress in rehabilitation in different ways (Malzer 1988, St Claire et al 1996). Thus the importance of patient-centred care has been recognised in physiotherapy (Grant 1994, Potter et al 2003b) along with general medicine, nursing and other allied health professions (Brown et al 1986, Fulford et al 1996, Henbest and Stewart 1990, Jarman 1995, Law et al 1995, Stewart et al 1989). While the patient-centredness construct lacks a universally agreed definition, Mead and Bower (2000) have identified five key dimensions:

1. The biopsychosocial perspective, which asserts that adopting a patient-centred approach will involve the practitioner in gaining an understanding of social and psychological issues as well as biomedical aspects of illness or injury.
2. The 'patient-as-person', which delves into the personal meaning of the illness or injury to the individual and involves exploring the condition as well as patient expectations, beliefs, feelings and fears.
3. Sharing power and responsibility recognises the discrepancy in the practitioner-patient relationship in favour of the practitioner in the biomedical framework, and promotes patient involvement in collaboration with the practitioner as integral to a patient-centred approach.
4. The therapeutic alliance acknowledges the importance of a positive interpersonal relationship between the practitioner and patient and recognises this to be an essential rather than an optional component of patient-centredness.
5. The 'practitioner-as-person' reflects the impact of the health professional on the relationship, and highlights the importance of the practitioner's self-awareness of emotions and behaviour.

In their study of expert practice in physiotherapy, Jensen et al (2000) identify the patient as the key source of knowledge in the consultation. They report that expert physiotherapists recognise the importance of gaining an understanding of the social and psychological context of the patient's world rather than just focusing on the diagnostic process. To achieve this, they note that expert physiotherapists have effective listening skills and adopt a patient-centred approach.

A key issue in the success of a patient-centred approach involves the practitioner and patient reaching a mutual understanding of the problem, as well as goals and priorities for management (Brown et al 1989). To be effective, there must be a thorough exploration of the agendas of both the practitioner and the patient (Brown et al 1986). However, the practitioner generally directs assessment according to his or her agenda (Faulkner 1998). This gives the practitioner the potential to develop and promote power in the practitioner-patient relationship.

The concept of power has been defined as coming from internal (eg knowledge, personality) or external (eg professional role, status of the organisation) sources (Redfern and Hull 1996). Williams and Harrison (1999) propose a model of the power dynamic in physiotherapy involving the interaction between therapist, patient and the environment and suggest that power inequalities in the relationship may be perpetuated by the attitudes, personal characteristics and professional control exerted by the therapist over the consultation process and exchange of information. The impact of the physiotherapist on the interaction has been endorsed by Payton and Nelson (1996) who studied patients' perceptions of certain aspects of their physiotherapy experience and found that patients were likely to strongly affirm the physiotherapist's viewpoint. Payton and Nelson (1996) also noted the potential of physiotherapists to encourage their patients' participation towards self-responsibility and self-determination.

In an in-depth analysis of a physiotherapist-patient consultation, Thornquist (1997) states that the physiotherapist controls almost every aspect of the consultation and dominates the interaction, with patient questioning designed to elucidate the problem(s) requiring treatment. However, Thornquist (1997) also concedes that how a physiotherapist exerts control is important, particularly the physiotherapist's use of language, active listening skills and promoting patient involvement. This highlights the importance of practitioner communication skills in the interaction, and is endorsed by research indicating that effective communication promotes patient adherence and enhances patient satisfaction (Gyllensten et al 1999).

In an exploratory study of patients' satisfaction with physiotherapy, May (2001) interviewed 34 patients with back pain who had received outpatient physiotherapy at one of two hospital sites during the previous year. The aim of the study was to identify areas of care that patients considered to be important for their satisfaction with physiotherapy. Five important factors were identified including:

- a professional approach by the physiotherapist that inspires confidence and involves education of the patient while exhibiting a personable manner of friendliness and empathy;
- the physiotherapist providing explanations for patients regarding the nature of the problem, prognosis, the treatment process and the patient's role;
- collaborative consultation by the physiotherapist with the patient to identify individual self-help needs and to monitor treatment effectiveness, while demonstrating active listening skills and responding to patient questions;
- structure of consultations to ensure flexibility in scheduling appointments, minimal patient waiting times, adequate one-to-one time with the physiotherapist and not feeling rushed; and
- good treatment outcomes (eg reduction or elimination of pain) and providing self-management strategies for patients.

May (2001) concluded that patient care should be tailored to meet specific patient needs, and that effective treatment outcomes require not only competence in certain techniques, but also that physiotherapists have a range of interpersonal skills to assist in patient management.

Aside from the aforementioned studies, few projects have focused entirely on exploring the patient's perspective in physiotherapy. In particular, there is a lack of published research to elucidate patient experiences in private sector physiotherapy and to gain patients' perspectives on aspects relating to the attributes of the service provided.

In physiotherapy, 'word-of-mouth' referral rates are second only to doctors' referrals as a means of recommendation for physiotherapy treatment (Sheppard 1994). As such, the importance of the private fee-paying patient to business success should not be overlooked, and the focus of service delivery should be to identify and meet consumer needs. The main purposes of this study, therefore, were to explore patients' perspectives regarding the qualities of a 'good' physiotherapist and to gain insight into the characteristics of good and bad experiences in private practice physiotherapy. It was anticipated that these findings would contribute to emerging research focused on enhancing patient-centred service delivery in private sector physiotherapy.

Method

The nominal group technique was used (Delbecq et al 1975), as it would provide an appropriate forum for generating a wealth of information that could then be organised by participants to reflect their input. The technique involves a highly structured meeting process that lasts up to two hours and includes the following five stages: introduction and explanation; silent generation of ideas; sharing ideas; group discussion; and finally, voting and ranking of ideas.

Subject recruitment A purposive sample of current and former patients (n = 26) willing to discuss their physiotherapy experiences were recruited from private practice settings, through medical centres and via word-of-mouth referral. To promote convenience and accessibility for patients, a range of meeting times and venues were utilised. Further, participants were offered recompense for travel expenses (eg taxi fares and parking fees) to attend meetings.

Procedure The Human Research Ethics Committee of The University of Western Australia granted ethical approval for this study. Informed consent was obtained from each participant along with demographic information including age, gender, occupation, marital status, income, educational level and specific details about each patient's most recent experience receiving physiotherapy treatment.

Table 1. The patient's perspective on qualities of a good physiotherapist.

Category	Ideas provided by 3 or more groups	Ideas provided by 1-2 groups
1. Communication ability a) Interpersonal skills	Listens, body language builds trust, demonstrates empathy	Asks appropriate questions, appropriately introduces him/herself, counsels patient, makes eye contact and speaks directly to the patient, receptive to what the patient has to say, demonstrates respect for the patient's point of view
b) Physiotherapist's manner	Caring, friendly, inspires confidence	Supportive, considerate, patient, genuine, polite, has a positive disposition, non-judgmental, enjoys the job, not egotistical
c) Teaching/education	Gives clear explanations about the problem and treatment at an appropriate level, explains what he/she is doing and why during assessment and treatment	Uses visual aids and gives written information to help the patient understand the problem and treatment, provides feedback on a visit-by-visit basis, demonstrates exercises, gives specific instructions eg what to do and what not to do
2. Other attributes a) Professional behaviour	Has appropriate skills and knowledge, is honest and knows his/her limitations, seeks further knowledge as required to help patients, keeps up-to-date with the patient's current and past history	Puts patient's needs first, dedicated and wants to be a physiotherapist, communicates with others also working with the patient, suggests alternatives that might help the patient, keeps up-to-date with skills and knowledge, maintains confidentiality, maintains a professional distance, treats each patient as an individual and appreciates differences between people eg physical, cultural
b) Organisational ability	Punctual	Keeps detailed notes, reliable
3. Service provided a) Diagnostic and treatment expertise	Provides self-help strategies eg a home exercise program and/or advice on what the patient can do for him/herself, follows up and actively involves the patient, provides an appropriate treatment to help the patient's problem eg pain relief, improve movement function	Provides a diagnosis, 'hands on' treatment, distracts the patient from their pain or problem
b) The environment	Creates a pleasant and welcoming environment within the physiotherapy practice, the physiotherapist puts the patient at ease during examination and treatment	The physiotherapist is clean and hygienic
c) Convenience and accessibility		The patient can be seen when he/she needs help, ease of access for injured or disabled people, caters to individual needs and is flexible eg time allocation and payment means

The principal researcher, a physiotherapist, acted as facilitator of each nominal group technique meeting and an independent observer familiar with the methodology attended each meeting to ensure uniformity of the process and to provide feedback to the facilitator.

In total, six nominal group meetings were held with three to five participants in each group. Each meeting was audio-taped and transcribed verbatim so that researchers could verify data and utilise the information for ongoing analysis once all meetings were completed. The issues discussed at each meeting were (i) the qualities of a 'good' physiotherapist as defined by patients, and (ii) the physiotherapy experience. To ensure a thorough exploration of these issues, data collection continued until no new ideas were being generated, ie until data saturation was achieved (Krueger 1994).

Piloting the nominal group technique To test the suitability and feasibility of the nominal group technique for this study, the process was pilot-tested with a separate group of five patient volunteers. The pilot testing ensured the protocol was realistic and that the questions patients were asked could be easily understood.

Data analysis All patients who participated in the nominal

Table 2. Patient quotes of good and bad experiences in physiotherapy.

Good Experiences *(Presence of qualities of a good physiotherapist, as listed in Table 1, shown in brackets after each statement)*	Bad Experiences *(Absence of qualities of a good physiotherapist, as listed in Table 1, shown in brackets after each statement)*
"One physiotherapist I had always took my phone calls when I was down and made an appointment for me so I could get treatment." (1b, 3c)	"When I was told it was posture that caused my problem at 60 years of age and it was too late to reform, but the problem was fixed by another physiotherapist." (1c, 2a, 3a)
"It was good to get to know my physiotherapist. She provided a friendly service and getting fixed was a good experience." (1b, 3b)	"My condition continually deteriorated when I was trying to do the exercises my physiotherapist gave me and she insisted I should keep doing them. I didn't realise at the time that the medication I was on made my fatigue worse…I thought my physiotherapist should know better since they knew what medications I was on and that something was wrong because I wasn't getting better, but she didn't listen or do anything. For me it was a trial and error process and a major hurdle in my recovery." (1a, 2a, 3a)
"My physiotherapist was friendly and open, explained what was being done and seemed to understand me as an individual." (1b, 1c, 2a, 3b)	"The pain associated with treatment was never a good experience." (3a)
"Tremendous relief from back pain with ongoing help with exercises to maintain that relief." (3a)	"The only bad experience I can recall relates to deep water running which my physiotherapist recommended even though I can't swim and don't like the water." (1a, 1b, 3a)
"When my physiotherapist recognised I was not improving as expected and referred me back to my doctor for another opinion." (2a)	"Being unsure of the treatment with insufficient explanation of the treatment being offered by the physiotherapist." (1c)
"Feeling comfortable with the manner and physical contact of physiotherapy and having a physiotherapist who answered my questions at an appropriate level when prompted." (1c, 3b)	"Having traction treatment." (3a)
"A physiotherapist who was sympathetic to my problem and tried their best to help." (1a, 1b)	"I was given a mis-diagnosis of an ACL rupture and left with a feeling of 'vagueness' about the injury." (1c, 2a)
"Being made to feel comfortable when needing to partially undress for assessment and treatment. The physical environment was comfortable and private. A comprehensive history was taken, I was informed about the problem and probably how it was caused and safety measures were taken during treatment (ie I was given a bell to ring and procedures were explained about the machine that was used)." (1a, 1c, 2b, 3b)	"One treatment that I got from a physiotherapist was pretty rough without any explanation of the treatment." (1b, 1c, 3b)
"The relaxed atmosphere created, and achieving my objectives have been good experiences in physiotherapy." (3a, 3b)	"Most of my treatments have been for relatively minor things and bad experiences relate more to my feelings of physical and emotional discomfort, rather then to the specific treatment provided. I got caught once with a change in physiotherapist at the practice I normally go to. In the past I had received treatment for my back without removing my top, but this new guy said "take your shirt off". It wasn't what I was expecting, I was taken aback. I hadn't checked my underclothes, you know to make sure I was respectable. I felt embarrassed and self-conscious and could not relax to be manipulated." (1a, 3b)
"Being treated by a physiotherapist who listened to me and gave me some relief from my pain, who I could call and talk to about my injury." (1a, 3a, 3b)	"I had one physiotherapist who was always interrupting treatment because of other activities, such as answering the phone and office work." (2a)
"The care and concern of my physiotherapist who showed me empathy." (1a)	"Being given a 10-minute treatment, the same treatment I was giving myself at home." (2a, 3a)
"Every time I see my physiotherapist I always get a friendly welcome." (1b)	"Taking forever to get an appointment when I wanted to be seen immediately for urgent help, and then giving me a list of exercises, sending me away and telling me to do them at home." (1c, 3a, 3c)
"A very caring physiotherapist who listened and treated me gently, who would rather work gradually than do too much, too soon." (1a, 1b, 2a)	"Me and the physiotherapist having conflicting opinions about my problem and treatment." (1a)
"Generally, I have had excellent experiences with physiotherapists. I have found them to be understanding, caring and sympathetic." (1a, 1b)	"I can recall a bad experience with one physiotherapist I went to once. He got the whole of his upper body bouncing off my spine, you know manipulating and he was a fairly big man. I came out seeing spots, had a
"Being able to ask questions about what was happening as I regained my ability to do more and I enjoyed the mobility classes as I made slow progress after my accident." (1a, 1c)	
"All my experiences as a patient have been good."	
"I have only had good experiences in physiotherapy."	
"My physiotherapist listened, was friendly and considerate towards me and gave a lovely massage. We were usually able to laugh and have light hearted conversation as well as serious and she could read between the lines." (1a, 1b)	

Good Experiences *(Presence of qualities of a good physiotherapist, as listed in Table 1, shown in brackets after each statement)*	Bad Experiences *(Absence of qualities of a good physiotherapist, as listed in Table 1, shown in brackets after each statement)*
"Having good rapport with my physiotherapist who successfully treated my injury so that I was able to return to sport." (1a, 2a)	headache. I got in the car and drove home, broke into tears and I swore I'd never go back to him. I went back to my doctor and I said I'm not going back to that physiotherapist and he said that I had to work through the pain barrier. I thought I'm the one with the pain, you're not. You know, it's a subjective thing where obviously the physiotherapist thought he was doing the right thing, but for me it was the wrong thing." (3a)
"Providing me with relief and possible solutions for my problem." (3a)	"I did have a physiotherapist once who thought she knew it all and ignored what I said. She had a preconceived idea about what treatment I needed and when I told her I couldn't afford to do everything she recommended, that I was on a tight budget she just couldn't understand. She was focused on my injury and not listening to me." (1a, 1b, 2a)
"I had a number of physiotherapists who were patient, intelligent, consistent, caring, compassionate, sincere and strong with their 'hands on' treatment." (1b, 3a)	"I received treatment twice a week for 6-8 months for a whiplash injury but did not get a lot of relief." (3a)
	Feeling uncomfortable and awkward and feeling like I was not getting value for money." (3a, 3b)
	"Being left alone in a room with a hot pack when I expected 'hands on' treatment." (3a)
	"Feeling like I was on a production line, attached to machines with no personal touch by the physiotherapist." (3a, 3b)
	"Being suspended by my ankles in a machine as a treatment for my back." (3a)
	"There was one physiotherapist who treated me who had such a big ego, he seemed to think he was brilliant. Had an attitude, like "I cure people, aren't I great". I presume you become a physiotherapist because you want to help people get better, feel better, to improve his or her quality of life, not so you can tell everyone how brilliant you are. I feel this conceit and arrogance is unacceptable." (1b)

group meetings were directly involved in analysis of the information they provided by rank ordering the categories they generated. As recommended by Lincoln and Guba (1985), a number of steps were taken to address trustworthiness in this research including:

1. Data collection continued until data saturation was achieved.
2. All meetings were tape recorded and transcribed verbatim with quotes from participants included to explain findings.
3. The choice of the nominal group technique methodology enabled participants to be directly involved in both data collection and analysis, ensuring findings and interpretations accurately reflected their thoughts.
4. An independent trained observer was involved with the nominal group technique to verify data, monitor consistency of the process and provide feedback to the facilitator at a debriefing session at the conclusion of each group meeting.
5. Data analysis that occurred subsequent to nominal group meetings involved analyst triangulation with two independent researchers. This process and the utilisation of the nominal group technique protocol further acted to minimise researcher bias in the interpretation of results.

Results

Demographics Thirty-nine per cent of the 26 patients were male, while 62% were female. The age range of patients was 20-79 years of age (mean = 48.8 years). The majority of participants were married (58%), with post-secondary school qualifications (65%) and income up to $40,000 per annum.

Sixty-one per cent of patients were private fee-paying and 39% identified themselves as compensable patients. At the

time of the study, 39% of patients were involved in ongoing physiotherapy treatment, 42% had ceased treatment in the last six months, while the remaining 19% had received their last treatment 12 or more months previously. Overall experience with physiotherapy was reflected in response to a question asking the number of occasions on which each patient had ever sought physiotherapy treatment (ie for separate injury problems). Half the sample reported one or two separate occasions, the other half three or four separate occasions.

Patient experience with non-physiotherapy providers was identified when patients were asked to reflect on their most recent injury and indicate involvement with other service providers in addition to physiotherapy. Fifteen per cent indicated no other treatment provider, 58% had seen one or two other providers, while 23% indicated they had seen three or more. The most common other providers were general practitioners, chiropractors and massage therapists. The full list of providers included: specialists in orthopaedics, neurology or psychology; a social worker; acupuncturist; naturopath; osteopath; hypnotherapist; and psychic healer. Of the remaining sample, 15% had seen no other providers and one patient did not answer the question.

Qualities of a good physiotherapist According to patients, the qualities of a 'good' physiotherapist were defined by three main categories. These were the physiotherapist's communication ability, other attributes of the physiotherapist, and the characteristics of the service provided by the physiotherapist.

Communication ability of the physiotherapist was ranked first or second by all groups of patients. When each category was further sub-divided with analyst triangulation, eight categories were identified as shown in Table 1.

The most important communication attributes of physiotherapists from the patients' perspective relate to the physiotherapist's interpersonal skills, manner and teaching ability. Also, physiotherapists are expected to be organised and demonstrate appropriate professional behaviour while providing a service that not only includes appropriate diagnosis and treatment but also provides self-help strategies for patients in a welcoming and easily accessible environment.

The physiotherapy experience As illustrated in Table 2, the vast majority of patients shared a mixture of good and bad experiences in physiotherapy. A small number of patients could only recall either good, or bad experiences, while a further two patients did not contribute any specific information in response to this issue.

Patients most often attributed good experiences to effective communication ability, followed by the high quality service provided by the physiotherapist. Conversely, the main commonality of bad experiences related to criticism of the service provided and then ineffective communication skills on the part of the physiotherapist.

Discussion

The purposes of this study were to gain the patients' perspective on the qualities of a 'good' physiotherapist and to identify the characteristics of good and bad patient experiences in private practice physiotherapy.

The findings from this study support earlier research in physiotherapy (Gyllensten et al 1999, Thornquist 1997) and endorse the importance of physiotherapists adopting a patient-centred approach and developing effective communication skills to optimise the physiotherapist-patient interaction.

The five dimensions of patient satisfaction reported by May (2001) were similarly identified by patients in this study among the attributes of a 'good' physiotherapist with the addition of the environment created by the physiotherapist in the private sector.

The most common attributes of good experiences in physiotherapy were found to relate to effective communication and the patient's perception of the high quality of the service provided. Conversely, when bad experiences in physiotherapy were recounted, patients most often described service quality (eg type, or impact of treatment provided) and physiotherapist communication to be deficient. Five of the patients who reported both good and bad experiences had only been seen for treatment of one injury, suggesting that the mixture of experiences they recalled most likely occurred with the same therapist. This finding suggests that even though these patients could freely recollect good experiences in physiotherapy, at certain times in the physiotherapist-patient interaction, the patients perceived problems that in some way compromised the relationship. There was no commonality of injury type, patients came from diverse backgrounds, were both compensable and self-funded, and were aged from 28 to 62 years.

Potter et al (2003b) reported a high degree of congruence between the expectations expressed by physiotherapists and patients in private practice, but patient priorities were different from those of physiotherapists. To some degree, this might explain areas of miscommunication that arise in the physiotherapist-patient interaction. By adopting a patient-centred approach that addresses the five factors described by Mead and Bower (2000), physiotherapists could minimise potential problems with physiotherapist-patient miscommunication and address any issues as they arise. However, to be successful physiotherapists need to feel comfortable and confident to discuss any issues that patients may raise, to share responsibility with patients and to be reflective of how their own behaviour contributes in such situations. For some physiotherapists who may not feel comfortable discussing certain patient issues, additional training in communication skills appears warranted. Support for such training is recommended by Potter et al (2003a) who reported that physiotherapists in private practice would like further education in both communication skills and behaviour modification

techniques to assist them in their work with patients.

Half of the patients in this study reported seeking physiotherapy treatment on three or four separate occasions indicating they had prior experience of physiotherapy. Of these patients, 69% (9/13) shared a mixture of good and bad experiences of physiotherapy. From the range of positive and negative comments made by these patients it is evident that in many cases they had changed physiotherapists, possibly as a result of a bad experience. Over half of these patients were private fee-paying, so for private practitioners who are competing with other health professions as well as other physiotherapy practices for clientele, this has implications for business success. With word-of-mouth recommendation being an important source of referral of patients to physiotherapy (Sheppard 1994), practitioners can ill afford the direct loss of patients who have had bad experiences, or their unfavourable comments that may dissuade other potential patients from seeking the services of a particular physiotherapist or physiotherapy in general. This highlights the need to seek patient input to identify their expectations and to get feedback about physiotherapy services in order to identify strengths and weaknesses from the perspective of the consumer.

On the issue of power in the physiotherapist-patient interaction, there were a number of quotes from patients, that suggest that some physiotherapists may have exerted power in the relationship that was not welcomed by patients. Whether physiotherapists would recognise the application of this power and its detrimental effect on the relationship is questionable, given that inequality exists in the practitioner-patient interaction in health care (Buchanan 1995). However, as Williams and Harrison (1999) point out, promulgation of power may evolve from characteristics of the therapist or through professional control of the consultation. Therefore, in order for the physiotherapist to be conscious of such a breach, he or she would need to demonstrate a high level of self-awareness of attitudes, values, needs, beliefs and role in the consultation. To achieve this end, further training of physiotherapists in the affective domain to improve the physiotherapist-patient relationship has been recommended (Potter et al 2003a and 2003b).

Conclusion

To date, the patient's perspective in private practice physiotherapy has received scant attention. This study addressed this issue and the findings contribute to emerging research about patient-centred service delivery in private sector physiotherapy. By actively seeking patient input, the importance of the patient to the success of the physiotherapist-patient interaction is highlighted, and the benefit of adopting a patient-centred approach in physiotherapy is reinforced.

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