PATIENT-CENTREDNESS:
A CONCEPTUAL FRAMEWORK FOR MUSCULOSKELETAL PHYSIOTHERAPY

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Abstract

Introduction
The centrality of the patient to health care has been increasingly recognised both politically and professionally. Patient-centred care has become synonymous with high-quality care and a number of studies have reinforced patient’s desire for, and the positive impact of the approach. Although the concept emerged over 30 years ago, it is still not clear what it is, upon what theories it is based, or how to measure it. Whilst the concept has been explored within medicine, nursing and other allied health professions, within physiotherapy there has only been minimal discussion. The aim of this research was to explore the meaning of patient-centred care in relation to low back pain, from the perspective of musculoskeletal physiotherapists.

Methods
Purposive sampling was initially used to select participants. Subsequently theoretical sampling was adopted whereby analysis of the data informed the sample selection. Nine musculoskeletal physiotherapists agreed to participate in the study. They ranged in experience from five to 25 years. Individual semi-structured interviews were adopted as the method of data collection. The interviews were audio taped and then transcribed verbatim. Analysis broadly followed the Grounded Theory approach outlined by Strauss and Corbin (1990). It consisted of a process of open, axial and selective coding. Constant comparative analysis resulted in the identification with a core category and three inter-related sub-categories and the development of a substantive theory of patient-centred care.

Findings
The core category was identified as a process of engaging the patient in a working alliance. The three sub-categories were: interpreting the problem; reconciling perspectives and developing an alliance. The process began with the initial assessment of the patient’s problem by the physiotherapist. As a result of the social interaction of interpreting the problem, the physiotherapist conceptualised the patient’s problem of low back pain into one that was congruent with their own
socially constructed meanings. The process of reconciling perspectives occurred simultaneously with that of interpreting the problem. In this interaction, the physiotherapist strived to reconcile the potential incongruence between their own belief system and that of their patients. This occurred primarily, although not exclusively, through the provision of information. Consequently the patient was perceived to have a greater awareness and understanding of their problem and a more realistic view of their role, and the role of physiotherapy, in its management. Developing an alliance with the patient was perceived to be integral to the process of engaging the patient as without it congruence was not possible. The core category of engaging the patient referred to the extent to which the patient participated in their management programme and was involved in the decision-making process. The participants clearly identified patient self-management as their goal of physiotherapy for low back pain. Consequently they invested considerable effort into promoting this goal to their patients. Successful engagement was perceived to result in a collaborative working alliance; a process unique to the individual therapeutic encounter.

The substantive theory integrates theoretical frameworks from a number of different disciplines and philosophies to provide a conceptual foundation for patient-centred care in musculoskeletal physiotherapy. The role of social interaction in creating meaning is explicated by complex responsive processes of relating, the therapeutic alliance is explained by the physiotherapeutic use of self, whilst the theory of communicative action provides a theoretical underpinning for the process of engaging the patient.

It was evident that the process of engaging the patient in a working alliance was not always straightforward. It was influenced by numerous factors including: the personal attributes of the individual patient and physiotherapist; the professional role of the physiotherapist and contextual factors such as resources, the services offered to patients with low back pain and the support and supervision within the physiotherapy department. Effective communication was identified as key to patient engagement. This did not occur in isolation but permeated the whole process. It was also clear that there were several issues that impacted on the ability of the participants to engage their patients in a working alliance. The clinical implications of these issues were considered under five broad areas: identifying
and addressing psychological factors; facilitating the decision-making process; establishing a conducive learning environment; facilitating self-management and enhancing communication. Suggestions for clinical practice were proposed in relation to each of the issues identified.

**Conclusion**

The findings of this study suggest that patient-centred care in musculoskeletal physiotherapy is a complex and multi-faceted process of engaging the patient in a working alliance. It has been conceptualised as a substantive theory that integrates a number of theoretical frameworks. Grounded theory can be used to either understand, or explain and predict. Whilst the findings have served to clarify the meaning of patient-centred care in relation to the individual therapeutic encounter, the predictive ability of the theory requires verification from further research.
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i. Concept building in relation to the working alliance

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ii. Key elements of complex responsive process of relating
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Acknowledgements

Firstly my grateful thanks go to the participants without whom this study would not have been possible. They gave up their valuable time willingly and their honest and pragmatic responses provided the data on which all the subsequent analysis was based. They clearly operate in a complex and rapidly changing clinical environment and as such they have my outmost admiration. My thanks go to Annie Wiggs for her permission to undertake the study in her Department and for her unstinting support in the implementation of the study.

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I am grateful to Dr Graham Stew for initially accepting me onto the Professional Doctorate course in 2004. At that time I had no idea how much it would change my life and the lives of those around me. The course also introduced me to some wonderful individuals who made the journey so memorable. I am grateful to Carol, Teenie, Jo, Debbie, Anne and Sue for their friendship throughout the course.

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out on many opportunities and I am so grateful for their understanding as I wrote my “big story”.

This study is dedicated to the memory of my Dad, Peter Sexton.
Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated in the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.
Chapter 1

Introduction

1.1 Introduction

This study set out to explore the concept of Patient-Centred Care (PCC) from the perspective of musculoskeletal physiotherapists managing patients with low back pain (LBP). The term “patient-centred medicine” was introduced over 30 years ago by Balint (1969:269) who contrasted it with “illness-orientated medicine”. Since then, PCC has become synonymous with high-quality health care. This chapter provides the rationale for the study by exploring the drivers behind the incorporation of PCC into health care. The meaning and significance of PCC are discussed. Musculoskeletal physiotherapy is considered and the focus of the study on LBP is justified. My theoretical stance for the study is presented and the significance of the study to the profession is explored.

1.2 Rationale for the study

The rationale for the study was provided by a number of political and professional drivers which were prevalent at the time of starting the study. The intervening years have seen the political drivers becoming even more topical.

1.2.1 Political drivers

Politically, the drive towards a patient-centred approach is overwhelming. Improving the patient experience has been central to Government policy for over a decade. “The National Health Service (NHS) Plan” (Department of Health, 2000) introduced the idea that patients would, for the first time, have a real say in the NHS and included the concept of making services more patient-centred. “Building on the Best” (Department of Health, 2003), reported on a consultation with over 100,000 people regarding what they wanted from the NHS. In summary, people wanted to be involved in decisions about their care and provided with personalised information and services. “The NHS Improvement Plan” (Department of Health, 2004) confirmed the drive towards a personalised service, giving people a greater say in how they are treated.
This gradual incorporation of the patient’s view into the assessment of health-care has been termed “the new subjective medicine” (Sullivan, 2003:1596).

During the course of my study two other reports were published emphasising the increasing role of the patient in their health care. “High Quality Care for All” (Department of Health, 2008) set out a vision for the NHS with quality at its heart. It focused on giving patients more information and choice and providing personal care. Importantly it linked funding to patient’s views on the success of their treatment and the quality of their experience. Finally, the new Coalition Government recently published their report “Equity and Excellence: Liberating the NHS” (Department of Health, 2010). The report argued that previous changes did not go far enough and suggested that patients should be at the heart of their healthcare. The Government’s vision was that improved health outcomes can only be achieved by fully involving patients in their care. To this end they suggested that shared decision-making becomes standard practice, with decisions being made in partnership with patients, rather than by clinicians alone. It has been suggested that the drive for greater patient participation in health-care may be associated with ulterior motives. Whilst giving the impression of compassion, it also encourages self-responsibility and hence less dependence on the State (Taylor, 2009). The Coalition Government acknowledged the financial pressures on the NHS, but countered this by striving for quality: “only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation” (Department of Health, 2010:1). It is evident that PCC was a pertinent topic when I started the study and continues to be so.

1.2.2 Professional drivers

The centrality of the patient in their health-care is recognised in all the standards of practice for physiotherapists. The requirements for patient respect, effective communication and the formulation of individual management plans are key elements in the Health Professions Council (HPC) Standards of Proficiency for Physiotherapists (Health Professions Council, 2005). The Quality Assurance
Agency’s (QAA) benchmark statements for Physiotherapy care (www.QAA) indicated that individual problem-solving underpins PCC. Finally the centrality of the individual patient for physiotherapists is underlined by its inclusion as the first standard in the professions Core Standards of Practice (Chartered Society of Physiotherapy, 2005).

1.3 The meaning of patient-centred care

Whilst it is apparent that there are considerable political and professional drivers behind the development of PCC in contemporary healthcare, it is not clear what it is, upon what theories it is based or how to measure it (Epstein, Franks, Fiscella, Shileds, Meldrum, Kravitz, & Duberstein, 2005). Indeed it is suggested that it has become something of a cliché (Sumsion, 1997). The considerable diversity of meanings was clearly illustrated by Gillespie, Florin and Gillam (2004) in their exploration of the understanding of PCC by different stakeholders. They concluded that the concept of PCC is “complex and contested” and proposed a continuum of patient-centred activities from public involvement in the organisation and planning of services, through to individual therapeutic interactions (Gillespie et al., 2004:147). It appears that to date, policy makers have focused on the organisational end of the spectrum, perhaps viewing the individual end as largely a clinical issue. This discrepancy could potentially result in a gulf between policy and the reality of the therapeutic encounter. In addition, it is argued that a failure to adequately define the concept may result in misinterpretation and inappropriate use (Dieppe & Horne, 2002).

The concept has perhaps been explored most fully within primary care medicine. Numerous definitions and descriptions have been proposed. They generally include aspects such as patient’s preferences; sharing of information; involvement in decision-making and the need for an understanding of the patient’s perspective. Mead and Bower (2000) suggested that patient-centredness is generally associated with what it is not – the biomedical model. There appears to be agreement in the literature that PCC is a multi-faceted construct. One of the most influential models views it as a holistic concept in which six interconnecting components interact with
each other in a format unique to each therapeutic encounter (Belle Brown, Stewart, Wayne Weston, & Freeman, 2003a).

Whilst PCC has been the subject of considerable interest in general practice, within physiotherapy, and in particular in musculoskeletal physiotherapy, it has not attracted the same level of discussion. This may be due to the pivotal role of primary care practitioners in delivering plans to improve the patient experience (Department of Health, 2004). Perhaps reflecting its status as a younger and less established discipline, the focus for physiotherapy has been on the drive for evidence-based practice, the emergence of biopsychosocial theory and the integration of these concepts into an evolving clinical reasoning framework (Jones, Edwards, & Gifford, 2002). During the course of my study, two papers were published that explored PCC in physiotherapy from the perspective of the patient. Cooper, Smith and Hancock (2008) reported six dimensions of patient-centredness of which communication was the most important. Kidd, Bond and Bell (2010) supported the pivotal role of communication and proposed a transformative spiral of increasing confidence, motivation and progress. Whilst these studies provided an insight to the patient’s perspective, studies have not considered the physiotherapists’ perspective and the extent to which it reflects that of the patient. As a profession, physiotherapists have been urged to address the issue of what PCC means in a physiotherapeutic context (Blackledge, 2005).

1.4 The significance of patient-centred care

The significance of PCC as a concept can be viewed from a number of perspectives. Duggan, Geller, Cooper and Beach (2006) argued that it is a “moral concept” on the basis of its consequences, its inherent ethical value and because it fosters the appropriate attitudes and beliefs in the clinician. In terms of consequences, there is a considerable body of evidence from medical research that patient-centred communication (an aspect of PCC) has a positive effect on outcomes including malpractice claims, satisfaction of the doctor and patients, patient adherence and health outcomes (Stewart, 2003; Taylor, 2009). A positive impact on chronic
musculoskeletal conditions is also reported (Bauman, Fardy, & Harris, 2003). It is apparent however that there is some discrepancy in the literature regarding patient preferences for patient-centredness. Little et al., (2001) found that primary care patients strongly favoured a patient-centred approach from their general practitioner. A more cautious conclusion was reached by Say, Murtagh and Thomson (2006) who found that preferences for involvement were very variable and influenced by a number of factors. Swenson, Zettler and Lo (2006) recommended that physicians should adopt a flexible style of communication to meet the range of patients' preferences. This is supported by Stewart (2001) who argued that being patient-centred involves taking into account patient’s desire for information and responding appropriately. PCC can also be considered as significant from an ethical perspective. It recognises the patient as a person rather than a condition, it respects the patient’s autonomy and values the alliance between the patient and health-care practitioner. Finally, PCC contends that clinicians should develop patient-centred attitudes and beliefs which in turn will influence their behaviour.

1.5 Musculoskeletal physiotherapy

Physiotherapy has been defined as:

“a science-based health care profession which emphasises the use of physical approaches in the promotion, maintenance and restoration of an individual's physical, psychological and social well-being and takes into account an individual's variations in health status” (www.QAA)

There appears to be some discrepancy in the literature regarding a concise definition of “musculoskeletal physiotherapy”. It has been described as a “non-invasive intervention which uses therapeutic movement to help overcome problems with everyday movements that are predominantly a consequence of pain” (Zusman, 2004:39). This definition clearly focuses on pain as the source of the patients problems. In contrast, Watson (1996:353) linked musculoskeletal practice with rehabilitation as a “problem-solving and educational process aimed at restoring a state of health or well being”. The scope of this definition is much broader with a greater emphasis on function as opposed to the causes of the patient’s problems. Interestingly, in their review of musculoskeletal physiotherapy, Refshauge and Gass
(2004:5) did not attempt a definition, opting instead to situate it in a broad paradigm with a number of underlying assumptions. Musculoskeletal physiotherapy encompasses a range of treatment techniques and modalities within which the term “manual therapy” reflects the utilisation of a predominantly “hands-on” approach to treatment and management.

The study focused on non-specific LBP for a number of reasons.

- it is the most common cause of physical disability in the working population and the problem most frequently encountered by musculoskeletal physiotherapists (Frost, Lamb, Doll, Taffe Carver, & Stewart-Browne, 2004);
- it presents a problem for health professionals as there is no definite diagnosis and few treatments have strong evidence of long term effectiveness (Foster, Pincus, Underwood, Vogel, Breen, & Harding, 2003);
- it is associated with a considerable body of literature to which the findings could be related.

1.6 Theoretical stance for the study

The theoretical perspective underpinning the study was that of symbolic interactionism, a form of interpretivism (Blumer, 1969). Symbolic interactionism is concerned with understanding human behaviour within a natural context and from the participant’s viewpoint. It recognises that individuals create meaning through interaction with others and with themselves. I perceived that through interaction with their patients, the participants would have defined what PCC means to them. Through an interview process that meaning would be communicated, modified and potentially a new meaning co-constructed. As the researcher, I was also challenged with taking the role of the participant and imagining their perspective of PCC. The methodology adopted for the study was that of grounded theory (GT); one of the main approaches to qualitative research.
1.7 Significance of the study

The significance of the study can be considered from two perspectives: firstly in relation to the development of a theoretical base for the profession and secondly in relation to the topic of PCC. In terms of the former, it is suggested that a profession is unable to attain credibility in the scientific community without a theoretical foundation. As long ago as 1989, physiotherapists were urged to develop a paradigm or philosophy for physiotherapy (Tyni-Lenné, 1989). Despite this, it appears that a theoretical basis for the profession is still lacking (Jensen, 2004). It is suggested that the patient–physiotherapist interaction has always been integral to physiotherapy practice (Noronen & Wikstrom-Grotell, 1999). The growing acceptance of qualitative research in physiotherapy means that research into this area of practice is now considered to be a credible alternative to quantitative research. My study can therefore be seen as contributing to the development of a professional paradigm of physiotherapy.

Secondly, my study can be considered in relation to PCC. It is suggested that a lack of an agreed definition for PCC has hampered conceptual and empirical developments (Mead & Bower, 2000). Additionally in this age of quantification of all aspects of quality of care, measurement of patient-centredness has been constrained by the lack of theoretical clarity. If PCC continues to be central to government policy, then its implementation requires ownership by patients and therapists alike and a clear understanding of its meaning in relation to the individual therapeutic encounter (Gillespie et al., 2004).

1.8 Structure of the thesis

My study took place over a three year period. It was modified from its original plan, new studies were published and I discovered literature of which I was unaware when I started. I began the study as a novice researcher. As I became increasingly familiar with my chosen methodology, my research skills were enhanced and I became increasingly confident in my analysis and interpretation of the data. As such it has been challenging to provide a comprehensive and cohesive account of the complexities of the study. Whilst I have attempted to accurately document the details,
the presentation in chronological order inevitably belies the intricacies and nuances of the whole process and the extent to which it became an all encompassing endeavour. I have incorporated my own personal perspective throughout the thesis so that the reader can obtain a sense of my own journey. The structure of the thesis is as follows:

Chapter 2: This chapter provides the background to the study. It contextualises patient-centred care in relation to the relevant literature and contemporary physiotherapy practice. My own personal interest in the concept is presented. The study focused on low back pain (LBP) and key issues associated with the management of this problem are discussed. The current practice of musculoskeletal physiotherapy is reviewed. The chapter culminates in the presentation of the research question and its objectives.

Chapter 3: This chapter provides an overview of the methodology of grounded theory and its underpinning philosophy. It details the eventual selection of the approach proposed by Strauss and Corbin (1998). It justifies the choice of interviews as the method of data collection as being congruent with the research question. Finally my own personal position as a researcher prior to embarking on the study is considered.

Chapter 4: This chapter details the implementation of the study. It considers the particular ethical issues associated with the use of interviews. The use of initial and purposeful sampling is discussed prior to a review of the procedure of data collection. Coding is the principal intervention in grounded theory and the analysis and interpretation of the data is discussed in detail. The chapter concludes with an audit trail which provides an overview of how the theory evolved.

Chapter 5: This extensive chapter presents the findings of the study. The sub-categories and core category are described in detail, illustrated with quotes from the participants and related to the relevant literature to present a theoretical conceptualisation of the findings. The chapter
concludes by providing a theoretical framework of patient-centred care in musculoskeletal physiotherapy.

Chapter 6: This chapter discusses the implications of the findings to practice. These are considered under five broad headings along with suggestions as to how the implications could be implemented. The contribution of the findings to knowledge is considered. The strengths and limitations of the study are acknowledged and recommendations for further research are made.

Chapter 7: This chapter provides a summary of the findings and implications of the study. It concludes by considering the role of grounded theory research in physiotherapy.

Throughout the thesis citations in the text assist the reader in accessing the relevant literature. Page numbers are included for books, quotes and key concepts. Where concepts are integrated throughout the article, only the year is provided.
Chapter 2

Background to the study

2.1 Introduction

This chapter provides the background to the study, contextualising patient-centred care (PCC) in relation to the relevant literature and contemporary physiotherapy practice. Initially my own personal interest in the concept is presented. This developed over a period of time and in relation to a number of issues that appeared to be unrelated, but combined to form the motivation behind the study. The literature of PCC in relation to primary care medicine is discussed. Much of the early exploration was undertaken in the United States (US). It is only in the past decade that this has gathered momentum in the United Kingdom (UK), and only recently in relation to Physiotherapy. Whilst PCC has been advocated politically and professionally and is considered as a moral concept (Duggan, Geller, Cooper, & Beach, 2005), limitations to its implementation have been recognised and these are considered. A key issue in relation to my study was that of managing low back pain (LBP) and this is examined. Finally, the context in which the study occurred is reviewed by considering the current practice of musculoskeletal physiotherapy. The chapter culminates in presentation of the research question and its objectives.

2.2 Personal interest

My interest in the concept of PCC arose from an anxiety, or “disturbance” I felt in my own area of practice (Brookes, 1976:11). The disturbance developed partly from my involvement in the assessment of students undertaking clinical practice modules as part of their master’s studies. A component of the assessment of the clinical practice modules involves an examination of a new patient by the student. During these assessments I became increasingly aware that students appeared to be so focused on the process of information gathering, that they frequently fail to fully engage with the patient, to ascertain the impact of the problem on the person’s life, to “understand the person behind the problem” (Higgs, Jones, Edwards, & Beeston, 2004:186) and to enable the patient to play an active role in their treatment programme. That is not
to say that the students were not sympathetic and caring, but perhaps that they missed an opportunity to maximise the therapeutic encounter and fully harness the patient’s potential to enhance their own recovery (Reilly, 2001). Whilst I acknowledged that the demands of an examination would clearly influence their behaviour, I also felt unease that there was a more fundamental issue at stake. The timing of this unease coincided with the publication of two papers that resonated with my concerns regarding physiotherapy practice. The first was a randomised controlled trial (RCT) and the second was a supplement to the Physiotherapy Frontline Journal.

The RCT compared one session of assessment and advice from a physiotherapist, with a course of physiotherapy for patients with LBP (Frost et al., 2004). Although the study found that patients in both groups improved, at the 12 month follow-up there was no difference between the groups. The findings were not reflected in the reports that followed in the National press. Comments such as “frequent physiotherapy is no better than good advice” (Daily Mail, 2004) were prevalent. In the furore that surrounded the publication of the study, Moore (2004), a columnist in a national paper, provided an interesting perspective. The columnist cast personal doubt on the study findings stating, “scientifically this may be the case, but humanly I don’t see how it can be”. The commentary suggested that patients feel “cared for” by their physiotherapist and that this was a key component of healing. Closer analysis of the Frost et al., (2004) paper revealed a number of findings that were not widely reported, and which were attributed by the authors to multiple statistical testing. Physical functioning and mental health improvements in the treatment group were significantly better at two months than in the advice-only group. Although the period over which patients were treated was not stated, it is likely that at two-month testing, a number of patients would have still been receiving treatment. This could indicate that the interaction with a physiotherapist and/or the intervention was worthwhile, despite the lack of clear difference between the groups at 12 months. The second publication focused on the term “patient-centred care” (Blackledge, 2005). It began by posing the question “what do we mean by patient-centred care?” It suggested that it involved placing the patient at the centre of their care, but concluded that further exploration and discussion of the concept was required in physiotherapy (Blackledge, 2005:3).
As I reflected on the study by Frost et al., (2004), the lay perspective by Moore (2004) and the lack of clarity surrounding PCC (Blackledge, 2005), I realised that I was struggling to reconcile some contradictory issues. On the one hand there was the value attributed to the therapeutic relationship by patients and the centrality of the patient to Government policy. On the other hand there was my perception that researchers and postgraduate students were not fully focused on the individual needs of their patients. These issues formed my own personal background and motivation to explore PCC in the initial assignments and thesis of my doctoral studies.

2.3 What is known about patient-centred care?

In qualitative research, an extensive review of the literature in the topic area is delayed to prevent the influence of existing theory and knowledge on the research process. As will be discussed in Section 3.4.3, the role of literature in GT is controversial. However, a review of the existing literature was required for ethical approval of my study and indeed further details were requested before Research and Development approval was granted (Section 4.3.1). As discussed in Section 1.3, at the start of my study literature relating to PCC in physiotherapy was limited. I therefore had to look outside the profession to others where the concept had attracted more attention.

My search strategy at this stage was very broad. I used a combination of terms for “patient” and “centred” including American and English spellings (patient-centered and patient-centred respectively) and combined this with care. The initial results were predominantly related to medicine. Subsequent searches included physiotherapy and its derivatives including therapy and physical therapy. I searched the main databases including Cinahl; PubMed; PEDro; Sage Publications; Science Direct; Web of Science and Web of Knowledge. In considering the main literature to provide the background to my study, I decided to focus on medicine. Whilst PCC has been considered by other professions, it has been explored most fully in medicine, particularly within general practice. Additionally, profession-specific studies have used the medical literature as the basis for their own reviews (e.g. Booth, 2008; Miller &
Gemmell, 2004). The relevant studies are now discussed and critiqued and gaps in the literature are highlighted.

An early exploration of PCC was undertaken in the United States (US) (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993b). The authors focussed on the experience of illness and healthcare from the perspective of the patient. They collected qualitative data from patients recently discharged from in-patient care, their families, medical and non-medical staff. From the extensive data they developed a quality framework primarily targeted at healthcare managers and policy makers. The framework identified seven dimensions of PCC (Table 2.1), which subsequently formed the basis of a survey instrument. This was used to explore the status of PCC in the US. One of the key findings of the survey was a resistance by health care professionals (HCP) to involve patients in “planning, designing or evaluating healthcare” (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993a).

<table>
<thead>
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<th>Dimension</th>
<th>Specific areas</th>
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| Respect for patients’ values, preferences and expressed needs | • Quality of life  
• Involvement in decision-making  
• Dignity  
• Needs and autonomy |
| Coordination and integration of care           | • Clinical care  
• Ancillary and support services  
• “Front-line” patient care |
| Information, communication and education       | • Clinical status, progress and prognosis  
• Processes of care  
• Facilitation of autonomy, self-care and health promotion |
| Physical comfort                               | • Pain management  
• Help with activities of daily living  
• Surroundings and hospital environment |
| Emotional support and alleviation of fear and anxiety | • Anxiety over clinical status, treatment and prognosis  
• Anxiety over the impact of the illness on self and family  
• Anxiety over financial impact of the illness |
| Involvement of family and friends              | • Accommodation of family and friends  
• Involving family in decision-making  
• Supporting the family as care giver  
• Recognising the needs of the family |
| Transition and continuity                      | • Information  
• Coordination and planning  
• Support |

Table 2.1: Dimensions of PCC (Gerteis et al., 1993b)
Whilst this work provides an interesting historical background to PCC, its applicability to my study is limited. The patients had received in-patient medical and surgical care as opposed to out-patient care for a musculoskeletal problem and the study was aimed at a specific audience. Arguably the most influential work in the area of PCC is that of Moira Stewart and her colleagues in Canada. The authors developed the concept of PCC in relation to medicine in the 1980’s and published the second edition of their work in 2003 (Stewart, Belle Brown, Wayne Weston, McWhinney, McWilliam, & Freeman, 2003). They posited PCC as a holistic concept, in which six interconnecting components interact with each other in a format unique to each therapeutic encounter (Figure 2.1) (Belle Brown et al., 2003a). The central component of “finding common ground”, was termed the “linchpin” (Belle Brown, Wayne Weston, & Stewart, 2003c:85). It was described as the process by which the patient and doctor attained a shared understanding of the patients’ problem; the goals of management and their respective roles in the management programme.

![Figure 2.1: Interactive components of the patient-centred clinical method (Belle Brown et al., 2003a)](image-url)
The authors claimed that their approach differed from others, being both a model and a clinical method, hence they adopted the term “patient-centred clinical method” (PCCM). As such it provided both a theoretical framework and strategies for implementation in practice. The latter was facilitated by highlighting the interrelationships between the components (Belle Brown et al., 2003a:9). The applicability of the model to the UK was broadly supported by Little et al., (2001). The researchers explored patient preferences for patient-centred consultation in general practice. They found that patients strongly wanted a patient-centred approach. Three important domains from the patient’s perspective were communication, partnership and health promotion. Additionally, it was argued that doctors should be sensitive to the preferences of patients in relation to patient-centredness. In a response to the paper, Stewart (2001) suggested that this and other studies supported an emerging international definition of patient-centred care.

A further reconceptualisation of PCC occurred in the US in the 1990’s. In 1992, the Pew-Fetzer Task Force was established to: identify the scope of issues involved in the interdependence of biopsychosocial factors in health and illness; identify the most pertinent issues to healthcare practitioners; identify barriers to the integration of biomedical and psychosocial factors and develop strategies to overcome the barriers. The report of the Task Force was published two years later (Tresolini & Pew-Fetzer Task Force, 1994). Whilst it reaffirmed the importance of the relationship between the patient and clinician in PCC, it argued that the relationships with other practitioners and the communities they serve were equally important. As such relationships were “prerequisite to effective care and healing” and the term “relationship-centred care” was proposed as more appropriate than PCC (Tresolini & Pew-Fetzer Task Force, 1994:10).

Beach and Inui (2006:S4) affirmed that relationships provided the context for “many important functions and activities in health care” and identified four inter-related principles of relationship-centred care (RCC) (Table 2.2). Whilst the focus of the principles was on the relationship between clinician and patient, the relationship of the clinician with their colleagues and the organisation in which they operate was
considered profoundly important. Additionally, RCC recognised that clinicians cannot work in isolation as the determinants of health are multifactorial. Consequently effective care requires clinicians to forge relationships with individuals from many different sectors. The least common dimension of RCC is the relationship the clinician has with themselves. It was suggested that the capacity of the clinician to function effectively is dependent upon their capacity for self-awareness and self-reflection (Beach & Inui, 2006).

<table>
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<th>Principle</th>
<th>Key issues</th>
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<td>1 Relationships in healthcare ought to include dimensions of personhood as well as role</td>
<td>The patient and the clinician bring their individual personhoods to the consultation.</td>
</tr>
<tr>
<td>2 Affect and emotion are important components of relationships in healthcare</td>
<td>Support is given to the patients through the emotional presence of the clinician</td>
</tr>
<tr>
<td>3 All healthcare relationships occur in the context of reciprocal influence</td>
<td>The clinician also benefits from the therapeutic encounter</td>
</tr>
<tr>
<td>4 Relationship centred care has a moral foundation</td>
<td>A genuine relationship will enhance the clinician’s behaviour and commitment to the patient</td>
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Table 2.2: Principles of Relationship-Centred Care (Beach & Inui, 2006)

The proponents of PCC rejected the reconceptualisation of PCC into RCC. They suggested that the overemphasis on the process of care deflected from the goal of the interaction (Belle Brown et al., 2003a). It is interesting that RCC has not entered the terminology in the UK. All the political and professional drivers adopted the term PCC (Section 1.2). The reason for this is unclear. Whilst it may reflect the divergent healthcare systems of the two countries, the philosophical underpinnings of the two charitable institutions that commissioned the report (Fetzer Institute; Pew Health Professions Commission) could be perceived to be very different to that of the National Health Service (NHS). In terms of advancing knowledge of PCC, the concept of RCC highlighted the affective dimensions of the relationship between the patient and clinician. In particular it emphasised the importance of a clinician who is authentic, empathetic and committed to their patients. It also contextualised the therapeutic encounter within a broader perspective of local, organisational and
societal influences. Finally, Pew-Fetzer Task Force report (1994) was the first that focused on all health professionals, not just doctors.

In an attempt to clarify the meaning of patient-centred medicine (PCM), Bensing (2000) viewed the concept from two perspectives: content and control (Figure 2.2). Incorporating the work of Stewart et al., (2003) he viewed the content to be one that focused on the patient’s illness rather than their disease; a biopsychosocial rather than a biomedical approach. He considered the control of the consultation in PCM to be shared; a process of mutual decision-making. Bensing (2000) suggested that patients may differ in the position they prefer on both axes. Consequently he supported the recommendation that doctors should be sensitive to the preferences of individual patients. Such flexibility and responsiveness to the needs of the individual patient is considered to be the essence of PCCM (Belle Brown et al., 2003c).

![Figure 2.2: Dimensions of patient-centred medicine (Bensing, 2000)](image)

In the UK the most influential work has been that of Mead and Bower (2000) who proposed a conceptual framework for PCM. The authors also contrasted PCM with the biomedical model but expanded this to include five distinct dimensions: a biopsychosocial perspective; understanding the individual’s experience of illness – the patient-as-person; sharing power and responsibility; the therapeutic alliance and
the influence of the personal qualities of the doctor – the doctor-as-person. The framework was broadly supported by a review of quantitative studies that attempted to measure patient-centredness in medicine. In addition, a considerable number of variables that could potentially influence the ability of the doctor to be patient-centred were identified. The behavioural interaction between the doctor and patient was placed at the centre of the framework. Potential influencing factors ranged from those distant to the therapeutic consultation, such as cultural norms, to those at the level of the consultation which were more likely to have an immediate effect. Factors relating to the individual patient and doctor, such as attitudes, knowledge and gender, were placed closest to the interaction.

The conceptual framework of Mead and Bower (2000) represented the first major exploration of the concept of patient-centredness in the UK. Whilst its findings provided a valuable perspective for my study, it has a number of limitations. The dimensions of the framework received support from the literature reviewed; however the relationships between the dimensions were not fully clarified. This may be because only quantitative studies were included in the review, a fact recognised by the authors. The papers reviewed also focussed on a single consultation between a doctor and patient. This may not have accounted for aspects of the dimensions that developed over time. Criticisms notwithstanding, the framework highlighted the complexity of the concept of PCC, particularly in relation to the influencing factors.

Despite the lack of an agreed definition, the concept of patient-centredness has been incorporated into the training of a number of healthcare practitioners including general practitioners and nurse practitioners (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001). As previously indicated (Section 1.3), physiotherapy as a profession has been much slower to explore the concept. The limited studies that have been undertaken are now discussed.

2.4 Physiotherapy and patient-centred care

The topic of expert practice within physical therapy has attracted considerable interest from a group of researchers in the USA. Led by Gail Jensen, the group
conducted a series of studies in the 1990’s which culminated in a theoretical model of expert practice. In the final study, therapists classified as experts on the basis of their clinical outcomes, were distinguished by a patient-centred approach to care (Resnik & Jensen, 2003) (Figure 2.3). This approach resulted from an interplay of other dimensions and guided the clinician’s style of practice. The therapists’ considered patient empowerment to be their goal of management, with patients viewed as active participants in the attainment of that goal. Collaboration, clinical reasoning, education and a good therapist-patient relationship were identified as strategies that contributed to successful patient empowerment. The study was relevant to my study from two main perspectives. Firstly the majority of the participants were experienced in out-patient orthopaedic practice and secondly the researchers adopted grounded theory as their methodology. However the participants were selected based on a retrospective audit of an outcomes database, a strategy not available in the UK.

Figure 2.3: A theory of expert practice (Resnik & Jensen, 2003)
It is only in the past three years that PCC in physiotherapy finally became a topic of study in its own right with the publication of two studies (Cooper et al., 2008; Kidd, Bond, & Bell, 2011). Both studies considered PCC from the perspective of the patient. Cooper et al., (2008) conducted 25 interviews with patients with chronic LBP who had been discharged from out-patient physiotherapy six months prior to the study. A framework analysis of the data resulted in the identification of six dimensions that the participants perceived as important for PCC in physiotherapy. These included: communication; individual care; decision-making; information-sharing; the physiotherapist and organisation of care. The importance of communication was highlighted by the authors, being common to all the dimensions.

The study by Kidd et al., (2011) was the first stage in the development of a patient perception instrument for the assessment of the clinical performance of physiotherapists. The study built on the work of Cooper et al., (2008) by recruiting participants with differing musculoskeletal conditions. Using grounded theory, five categories of patient-centred physiotherapy were identified: ability to communicate; confidence in explanations and attitudes; knowledge, expertise and professionalism; an understanding of people and an ability to relate; and transparency of progress and outcome. Based on the findings, PCC in physiotherapy was conceptualised as a “transformative spiral of increasing confidence, motivation and progress” (Kidd et al., 2011:160). A professional relationship was identified as integral to the process and this was viewed as an active partnership. It was suggested that the patient’s confidence increases in response to the self-confidence and expertise of the therapist so that they engage in their programme of physiotherapy.

There are a number of commonalities in the findings of the studies. Additionally the authors of both papers recognised the resonance of their findings with the conceptual model of Mead and Bower (2000). Interestingly there are also some key differences, which may reflect the different methodological approaches of the researchers. Perhaps reflecting its origins in symbolic interactionism (although this was not made explicit), the theory by Kidd et al., (2011) is a dynamic process which has at its centre the interaction between the patient and physiotherapist. Whilst the theory was
underpinned by effective communication, it was suggested that this is not an isolated dimension but pervades the entire process. In slight contrast, the model by Cooper et al., (2008) appears more static. Whilst arrows indicate the relationships between the six dimensions, an interactional component appears to be lacking. Despite its stated commonality to all dimensions, communication appears as a distinct dimension. The findings of both the studies do however highlight the complexity of the concept of PCC and the profound importance patient’s place on communication skills of the physiotherapist.

2.5 Issues relating to patient-centred care

A number of limitations to the implementation of PCC have been recognised. These include its apparent conflict with evidence-based practice and secondly the professional remit of the clinician.

PCC can be considered as one of the two major paradigms influencing contemporary healthcare; the second is that of evidence-based practice (EBP). The conflict between the two has been the topic of some discussion in medicine. EBP has been accused of being disease rather than patient orientated; centred on the clinician rather than the patient; valuing the results of RCTs’ over other forms of research; and failing to recognise the patients as experts in their own problems (Bensing, 2000; Taylor, 2009). Indeed it has been suggested that they appear to belong to “separate worlds” and the challenge for clinicians is to integrate the two paradigms (Bensing, 2000:18). In contrast the proponents of PCCM have argued that PCCM and EBP are “synergistic” (Belle Brown et al., 2003a). Firstly there is an increasing volume of literature to support the PCCM and secondly it is congruent with the definition of EBP in its broadest sense. EBP has been defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996:71). It involves integrating individual clinical expertise with research evidence. Hence it is considered to assist the clinician in combing clinical judgement with the patients’ needs and preferences (Belle Brown et al., 2003a).
In terms of physiotherapy, this issue has not attracted much attention. It is evident that the profession is committed to the philosophy of EBP. The past decade has seen considerable development in the basic and applied sciences of musculoskeletal physiotherapy (Boyling & Jull, 2004). However, this focus on the generation of theoretical knowledge generated by quantitative research has been criticised. Researchers have been called upon to recognise the value of qualitative research in obtaining a richer insight into patients and their experiences (Johnson & Waterfield, 2004). It is also argued that some of the concepts of EBP are incompatible with physiotherapy research (Bithell, 2000). Whether the same criticism can be levelled at physiotherapy practice has not been addressed.

The second potential dichotomy between PCC and clinical practice is the issue of subjectivity and objectivity (Taylor, 2009). On the one hand there is the subjective experience of the patient, whilst on the other there is the requirement of the doctor to structure and objectify the patient’s presenting signs and symptoms. It is suggested that doctors and patients talk and think differently and this can be problematic in relation to problems that cannot be given a definitive diagnosis (Taylor, 2009). This issue is particularly pertinent when it comes to the management of LBP. The focus of my study was PCC in relation to LBP and the issues surrounding its management are now discussed.

### 2.6 The management of low back pain

LBP presents a problem for doctors and health professionals as there is no definite diagnosis and few treatments have strong evidence of long term effectiveness (Foster et al., 2003:401). It has variously been described as a “diagnostic enigma” (Kent & Keating, 2004:1022) and an “elusive phenomenon” (MacNeela, Gibbons, McGuire, & Murphy, 2010:478). In considering the challenges it presents to clinicians, it is useful to review the historic management of back pain, the changing trends in its management and the ongoing issues surrounding its classification.
2.6.1 Historical perspective

Waddell (2004:67) has suggested that current medical management of LBP has been profoundly influenced by key ideas from the 19th century. At that time it was considered that back pain was due to an injury to the spine and should be treated by orthopaedic principles, paramount of which was rest. As a result healing would take place and the patient would be cured. In the 20th century the discovery of the intervertebral disc led to an explosion in spinal surgery. It has been argued that this increased the influence of orthopaedics and “distorted healthcare for the 99% of people with back trouble who do not have a surgical condition” (Waddell, 2004:55). It propagated the belief that back pain was a mechanical problem and hence the patient could expect it to be repaired.

Back pain has been described as “20th century medical disaster” as evidenced by rising trends for work loss and sickness and invalidity benefit, in the absence of any increase in the prevalence of the condition (Waddell, 2004:1). Twelve per cent of sick days are attributed to LBP making it the second most common medical reason for work loss (Clinical Standards Advisory Group, 1994). In 1998, physical treatments for back pain cost the UK almost £500 million, of which physiotherapy accounted for £251 million (Maniadakis & Gray, 2000). In response to the economic costs associated with LBP, a number of reviews were initiated around the world and guidelines were produced. In the UK the reports by the Clinical Standards Advisory Group (1994) and Royal College of General Practitioners (Waddell, Feder, McIntosh, Lewis, & Hutchinson, 1998) provided guidance for the management of acute and recurrent LBP. Broadly the guidelines advised a “diagnostic triage” to identify patients with “red flags” (those with serious spinal pathology requiring prompt medical attention); patients with radicular pain from nerve root compression and patients with non-specific LBP. For this last group the reports recommended symptomatic management, reassurance and encouragement to patients to manage their problem. The reports also recommended a “psychosocial assessment” of patients who had not responded to routine therapy in six weeks to identify any “yellow flags”, factors which have been found to be predictive of chronic disability. In reality it was recognised that
the majority of patients presenting to physiotherapy had experienced their symptoms for many weeks and had frequently experienced previous episodes of back pain (Watson, 1999). It was therefore recognised that the psychosocial assessment should be undertaken by a physiotherapist. During my study, guidelines for the early management of persistent LBP were published (National Institute for Health and Clinical Excellence, 2009). This provided evidence-based advice for the management of non-specific LBP of more than six weeks and less than 12 months duration. The central focus of the guidelines related to self-management. Treatment options included exercise, manual therapy or acupuncture with the aim of reducing pain and its impact on the individual's function.

2.6.2 Biopsychosocial model of management

In the absence of a clear pathophysiological explanation for chronic LBP to direct treatment, attention has shifted from a traditional biomedical approach to a biopsychosocial model (Foster et al., 2003). This approach integrates the "bio" or medical perspective, with the patient's perspective including their beliefs about the causes of the pain, their expectations and concerns regarding the future (Goldingay, 2006b:57). Whilst research has emphasised the importance of psychosocial factors in the development of chronicity, the efficacy for a biopsychosocial approach has yet to be demonstrated (Foster et al., 2003; Van der Windt, Hay, Jellema, & Main, 2008). Despite this, the biopsychosocial model has become the “standard preferable approach” to managing chronic LBP (MacNeela et al., 2010:977). A psychosocial assessment was recommended by the CSAG (1994) and RCGP (Waddell et al., 1998) reports and physiotherapists have been urged to give this information the same significance as information relating to the patient's symptoms (Goldingay, 2006b:57).

2.6.3 Sub-classification of low back pain

Despite the absence of specific diagnostic criteria, it is apparent that health care professionals continue to strive to attach labels to back problems. Kent and Keating (2004) found that that the majority of primary care clinicians in Australia believe that non-specific LBP is a heterogeneous condition consisting of several sub-groups. In a
follow-up study they found that 84% of clinicians indicated a pathoanatomical source for the problem (Kent & Keating, 2005). In a study by Foster et al., (1999) physiotherapists indicated that they most frequently managed patients with degenerative changes, sciatica, postural problems and disc prolapse. However the participants were requested to select from a pre-determined list of possible diagnoses which may have biased the results. A relatively new mechanism of classification that has grown in popularity within physiotherapy is one proposed by O’Sullivan (2005). This classifies non-specific LBP into three broad sub-categories, the largest of which includes patients whose symptoms are mechanically induced leading to an increase or reduction in spinal stability. However, in a recent appraisal of the evidence for the sub-grouping of LBP, Kamper et al., (2010) found scant evidence for any classification system.

It is evident that the management of LBP presents health care practitioners with a considerable challenge. One of the key issues is that in many cases a definite diagnosis is not available. Consequently there is a potential tension between the subjective experiences of the patient and the inability of the clinician to objectify and legitimise the patient’s problem. The findings of a study into PCC in relation to LBP clearly have to be considered in light of such issues.

2.7 Current musculoskeletal physiotherapy practice

PCC also needs to be contextualised in terms of contemporary musculoskeletal physiotherapy practice. In current practice, the first appointment is termed the assessment, a systematic process of information acquisition which guides the subsequent management of the patient’s problem. It is broadly divided into a subjective component; an interview, and an objective component; a physical examination. The history is considered to be the most important part of the assessment as it provides the basis for the generation of hypotheses regarding the patient’s problem (Refshauge, Latimer, & Maher, 2004). These are subsequently tested in the physical examination. The assessment culminates in the formulation of a physiotherapy diagnosis relating to the patient’s presentation and the development of a management plan (Jones, Jensen, & Edwards, 2008). The assessment enables the
physiotherapist to obtain a thorough understanding of the patient and their problem, creating professional certainty, often in the face of considerable clinical ambiguity.

Traditionally, physiotherapists are trained to assess and examine patients using a predominantly biomedical process. In recent years this has evolved to incorporate psychosocial elements. As a result of a grounded theory study, Edwards, Jones, Braunack-Mayer and Jensen (2004a) proposed that physiotherapists utilised a “dialectical” model of reasoning incorporating diagnostic and narrative components (Figure 2.4). Diagnostic reasoning is the “formation of a diagnosis related to physical disability and impairment” (Edwards et al., 2004a:324) with due consideration of pain mechanisms, pathology and other factors that could potentially contribute to the problem. It is associated with a traditional impairment-based assessment. In contrast, narrative reasoning involves the understanding of patients’ illness experiences, their perspective and beliefs. It was suggested that clinicians adopt a number of reasoning strategies to reconcile these two processes. Whilst the model was based on data collected from six therapists in three fields of physiotherapy practice: orthopaedic; neurological and domiciliary care, it has received some support in musculoskeletal physiotherapy (Smart & Doody, 2007).

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<tr>
<th>Reasoning process</th>
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<tr>
<td>Hypothetico-deductive (Diagnostic reasoning)</td>
<td>Procedural Interactive Collaborative Teaching Predicative Ethical</td>
<td>Narrative reasoning</td>
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<td>Generation of knowledge</td>
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<td>Quantitative/scientific paradigm</td>
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<td>Type of action/learning</td>
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<td>Instrumental</td>
<td>Communicative</td>
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Figure 2.4 Dialectical reasoning (Edwards et al., 2004a)
2.8 Research question and objectives

My research question underwent several modifications prior to the study. Initially I planned to explore the perceptions of PCC with both patients and physiotherapists. However, due to delays in attaining ethical approval and the time required for analysis of the data, it became apparent that this was not going to be feasible. The focus was therefore narrowed to include only the perspective of physiotherapists. My research question was therefore:

**What are the perceptions of patient-centred care in contemporary musculoskeletal physiotherapy practice?**

The objectives for the study were:
- to explore musculoskeletal physiotherapists’ views of patient–centred care;
- to use the analytical techniques of Grounded Theory to interpret the data;
- to develop a theory of patient–centred care in the management of LBP by physiotherapists.

2.9 Summary

The concept of PCC has attracted limited attention in the UK. Within physiotherapy, two studies have been conducted (Cooper et al., 2008; Kidd et al., 2011). These provided a valuable insight into the patients’ perspective. Referring to the study by Resnik and Jensen (2003), Cooper et al., (2008) suggested that PCC has been discussed from the perspective of the professional. However, a close look at the study by Resnik and Jensen (2003) indicates that PCC was not the topic of the investigation, but a theoretical conceptualisation of the practice of expert clinicians.

To date, PCC has not been explored from the perspective of musculoskeletal physiotherapists in the UK. The uncertainties surrounding the management of LBP indicated that the concept may be a challenging one for physiotherapists. My recognition of these issues, alongside an increasing realisation of the relevance and value of qualitative research in relation to physiotherapy (Gibson & Martin, 2003), suggested that this was an important and pertinent area to explore. The next chapter
considers the methodology adopted for the exploration of the concept of PCC in musculoskeletal physiotherapy.
Chapter 3
Methodology

3.1 Introduction

The term “methodology” is often used “loosely” (Carter & Little, 2007:1318) and “methodology” and “methods” are frequently used interchangeably (Norton, 1999:32). In this chapter the term methodology refers to the principles that guided the research process. It is an explanation and justification of the methods, providing a theoretical basis from which the methods can be analysed and evaluated (Carter & Little, 2007:1318). Chapter 4 (the Method) will refer to the specific techniques related to data collection and analysis. The methodology adopted for this study was Grounded Theory (GT), a qualitative approach to research developed in the 1960s by two American sociologists, Barney Glaser and Anselm Strauss. The two originators eventually adopted divergent and antagonistic approaches and this will be discussed later in this chapter. I was drawn to GT for a number of reasons:

- it is a valuable methodology for the study of interpersonal activities (McCann & Clark, 2003a);
- it is useful where there is a lack of adequate theory to explain or predict behaviours (Bluff, 2005:147);
- it can offer a new approach to an existing problem (Bluff, 2005:147);
- it can result in interventions which may improve patient care (Hutchinson, 1993:210) or from my own perspective enhance curricula;
- it facilitates the shift from quantitative to qualitative research (Smith & Biley, 1993).

Finally the most persuasive argument for me as the researcher, was articulated by Cutcliffe (2005:423) who stated that “qualitative research needs to pass the ‘so what?’ test”. It needs to do more than simply describe what is going on in the data. Jensen (2004:97) suggested that, as a profession, physiotherapy is “theory poor, lacking models and frameworks that assist in linking theory and practice”. My perception was that GT offered me the opportunity to obtain a greater understanding of patient-centred care and to generate a credible theory towards a goal of improving the quality of patient care.
GT is considered as a methodology by Crotty (1998:4), as a set of methods by Charmaz (Charmaz, 2006:9), a method by Hutchinson (1993:183) and as both by Cutcliffe (2005:422). In this study I adopted the classification by Crotty (1998:4) and adapted this to represent my philosophical stance for this study (Figure 3.1).

Figure 3.1: The four elements of the research process (Crotty, 1998) and my philosophical stance

Hutchinson (1993:181) suggested that research methodology is not a “haphazard bag of tricks”, but that it is linked to a philosophical perspective. Norton (1999) also considered that it is important to recognise this in order to maintain rigour when generating a GT. In this chapter I will discuss the philosophical basis for GT and how this has shifted since its inception over 40 years ago. I will consider how my choice of GT was profoundly influenced by my developing awareness of the concepts of knowledge and reality and their relationship to methodological issues. I will go on to explore my role as a researcher, my underlying philosophical assumptions, personal ontological and epistemological stance and its relationship to this study. Finally I will discuss the extent to which my chosen method is congruent with GT as a methodological approach.

3.2 Epistemology and ontology

The terms epistemology and ontology are frequently used in research literature. Ontology refers to assumptions made about the nature of reality (Crotty, 1998:10),
whether it is external to the individual or the product of the individual’s consciousness. Epistemology is the theory of knowledge; it considers how knowledge of reality may be gained (Norton, 1999:32). Crotty (1998:10) did not make overt reference to ontology in his representation of the research process contending that issues relating to the two concepts tend to emerge together. He was also critical of the confusion and misrepresentation of ontology in the literature. Carter and Little (2007:1319) also argued for the importance of epistemology in their conceptual framework for qualitative research. They stated that epistemology is “inescapable”, and that a theory of knowledge should be actively adopted by researchers. The authors illustrated how the methodology provides a justification for the methods which produce the findings of the research process. These findings are the basis for new knowledge (Figure 3.2). Epistemology is influential in modifying the methodology and evaluating the new knowledge (Carter & Little, 2007). Whilst I had explored the concept of epistemology early on in my doctoral studies, it remained a somewhat abstract concept and I had failed to grasp its practical significance and applicability to my study. Carter and Little (2007) have suggested that it is not unusual to struggle with the concept, but it is vital to recognise the role of epistemology in the research process.

![Figure 3.2: The relationship between epistemology, methodology and methods (Carter & Little, 2007)](image-url)
In reflecting on this I recognised how my epistemological position at the start of my doctoral studies had been determined by my professional background. The physiotherapy profession has been characterised by its “enthusiastic commitment” to “positivism” (Carpenter, 2004:2) and this is reflected in my own physiotherapy training, post-qualification education and research experience. This background has been reinforced by the profession’s commitment to the Evidence Based Practice (EBP) hierarchy of evidence, which champions experimental quantitative methodologies and in particular the randomised controlled trial (RCT) (Gibson & Martin, 2003).

Positivism is underpinned by the epistemological perspective of objectivism and ontological perspective of realism. The former assumes an objective world where “things exist as meaningful entities independently of consciousness and experience” (Crotty, 1998:5), whilst the latter posits that this reality is recognised and shared by individuals (Walliman, 2005:205). The goal of positivist research is objective knowledge; to represent and measure, predict and explain causal relationships between variables, building upon what is already known and seeking a universal truth. From this perspective it is assumed that scientific methods are appropriate for the study of social phenomena because behaviour is governed by law-like regularities (Snape & Spencer, 2003:6). Through my doctoral studies I was exposed to a body of literature that highlighted to me the limitations of the positivist perspective for healthcare research. Helders (2004:6), for example, indicated that the controlled environment and homogenous nature of experimental groups is far removed from the real world of physiotherapy practice. Jones, Grimmer, Edwards, Higgs, & Trede, (2006:3) concurred stating:

“a close look at many of our own RCTs reveals an incomplete picture where the impact the health problem and the physiotherapy intervention had on research subjects’ lives is not fully elucidated, leaving those patients who failed to respond as mere statistics, outliers and unheard voices”.

Whilst an objective, ordered and rational world is appealing I recognised that quantitative scientific research was unrealistic and inappropriate for my research question.
Since the second half of the twentieth century the dominance of positivism has been challenged as its limitations became increasingly apparent. Gephart (1999) suggested that the challenge has come from two alternative traditions; interpretive constructionism and critical postmodernism. Whilst the former challenged positivism for “ignoring the unique personal theoretical stances” upon which each person bases their actions (Walliman, 2005:204), the latter, a combination of critical theory and postmodernism, challenged the “value neutral” nature of positivism for failing to address exploitative social issues such as inequality and oppression (Gephart, 1999). Although both traditions raise “fundamental philosophical challenges for positivism” (Gephart, 1999) the interpretive constructionism perspective appeared to be more relevant to my research question with its focus on the personal perspective of the research participants.

Interpretivism is underpinned by the epistemological perspective of constructionism which rejects the objective perspective of human knowledge. There is no universal truth; meaning is not discovered but constructed through the interaction between individuals and their world. In contrast to the ontological perspective of the objectivist, the constructionist believes that truth and meaning do not exist in an external world but are created by the individual’s interactions with the world, a stance termed “relativism”. Research in the interpretivist paradigm aims to discover “why people do what they do” and possibly uncover taken for granted knowledge, meanings and rules of social life (Norton, 1999:38).

In exploring the philosophical basis for my study I encountered the first of many controversies relating to my chosen methodology. Whilst the early writings of GT focused on strategies rather than its philosophical basis, it is generally considered that GT was developed within the post-positivism paradigm with an objectivist epistemology, and critical realist ontology (Annells, 1996; McCann & Clark, 2003b). This holds the view of a single reality, but unlike positivism it recognises that it is not possible to fully understand this reality. Kennedy and Lingard (2006) and Bryant (2003) recognised an objectivist perspective in many of the statements and the terminology of the early GT theory texts. In 1990, Strauss and his subsequent
collaborator Corbin, published the “Basics of Qualitative Research” in which they detailed a highly complex process of systematic coding (Strauss & Corbin, 1990). Annells (1996) recognised a shift to a more relativist ontology in this text.

Whilst many GT researchers have continued to work in a post-positivist paradigm, others have moved towards a constructivist\(^1\) perspective (Bryant, 2003; Charmaz, 2006). Charmaz (2006:130) differentiated between objectivist grounded theory, situated within the positivist paradigm and constructivist grounded theory, which lies in the interpretive perspective. However, Glaser (2002), has contested the existence of constructivist grounded theory as a “misnomer”. In a passionate defence of what he termed “classic” grounded theory, he argued that GT utilises many forms of data, not just interviews. Consequently the impact of the researcher on the data is just one variable to consider and is addressed through the constant comparative techniques of the analysis. Bryant (2003) has argued that Glaser’s position is untenable given the limitations of positivism that have emerged in the last few decades.

### 3.3 Theoretical perspective

A theoretical perspective is the philosophical position, the set of assumptions, from which the methodology is derived (Crotty, 1998). Whilst Glaser (2002) was critical of constructivist GT, he did not articulate his own philosophical position and hence is still viewed as a critical realist (McCann & Clark, 2003b). In the latest edition of their book, Corbin and Strauss (2008:2) stressed the dual influence of pragmatism and symbolic interactionism in providing a framework for GT. According to the philosophy of pragmatism, the meaning of objects depends on how the individual intends to use them; objects are contextualised in relation to goals. In studying humans, pragmatism dictates that the focus should be on action, what individuals are doing, rather than on personality or society (Charon, 2004:31).

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\(^1\) Charmaz (2006) appears to be using the terms Constructionism and Constructivism interchangeably. Crotty (1998) uses Constructionism to acknowledge a historical, cultural and social perspective to the construction of meaning and Constructivism to place the unique experience of the individual mind at the centre. The former term is used in this study.
Symbolic interactionism (SI) grew particularly from the work of the pragmatist George Herbert Mead (1863-1931). It is through the writings of others, especially one of his students, Herbert Blumer (1900-1987), that his work became so influential. Based on the work of Mead, Blumer (1969) developed his own version of SI and it is this work I found particularly helpful in my understanding of the concept. SI can be considered as a perspective within social psychology. As a perspective it has its limitations, Charon (2004:13) admitted “it is far from perfect”, however Blumer (1969:47) asserted that it is a “down-to-earth approach to the scientific study of human group life and human conduct”. Blumer (1969:1) described three premises on which the concept rests:

- humans act toward things on the basis of the meanings that the things have for them;
- the meaning of the things is derived from social interaction with others;
- the use of meanings occurs through a process of interpretation.

Based on these premises Blumer (1969:6) posited six “root images” upon which SI is founded. In the first comprehensive review of the concept, Rose (1962:4) outlined five assumptions that underpin the theory. More recently Charon (2004:28) detailed five central ideas. Whilst the similarities between the authors’ analyses of the concept is clear (Table 3.1), reconciling the differences in emphasis and the relevance to GT proved more challenging.

In SI the focus is on interaction, both the dynamic social interaction between individuals and the thinking within the individual. As a result of these processes, individuals define what is taking place in the present situation, the environment, and decide on how to act. Reality is therefore considered as socially defined and objects, including physical ones, are given meaning through social interaction and are therefore termed “social objects” (Charon, 2004:45). Humans define these objects by firstly naming them and secondly, perhaps more importantly, learning their use (Charon, 2004:46). Blumer (1969:69) suggests that as a result of this analysis of objects, humans are “seen as living in a world of meaningful objects”, one which is socially produced.
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<tr>
<td>1</td>
<td>● Human society consists of people engaging in action</td>
<td>● Man lives in a symbolic environment as well as a physical one and can be stimulated to act by symbols as well as physical stimuli.</td>
<td>● Social interaction is central to human behaviour.</td>
</tr>
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<td></td>
<td>● The meaning of objects is defined through social interaction.</td>
<td>● Symbolic communication is a social process where both participants contribute to the content of the communication.</td>
<td>● It is an on-going activity they act in relation to the acts of each other and take into account one another’s acts.</td>
</tr>
<tr>
<td>2</td>
<td>● The human world consists of objects</td>
<td>● Most of adult human behaviour is learned in symbolic communication.</td>
<td>● Human action is influenced by interaction within the individual – thinking.</td>
</tr>
<tr>
<td></td>
<td>● The “self” emerges from a process of social interaction in which other people define the individual.</td>
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<td></td>
<td>● The “self” enables the individual to engage in a social interaction with themselves.</td>
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<td>3</td>
<td>● Humans posses a “self” whereby the individual can be an object of their own action.</td>
<td>● The meaning and values of symbols often occur in clusters which have different terms:</td>
<td>● Humans act in response to what is occurring in the present situation.</td>
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<tr>
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<td>● The “self” emerges from a process of social interaction in which other people define the individual.</td>
<td>o Role refers to meanings and values that guide an individual’s behaviour in a given social setting. The definition of an individual as a specific role-player is termed “me”.</td>
<td>● It depends on their current definition, interaction and thinking.</td>
</tr>
<tr>
<td></td>
<td>● The “self” enables the individual to engage in a social interaction with themselves.</td>
<td>o Structure refers to meanings and values related to a social setting</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>● Human action consists of interpreting what is presented to them and constructing a line of action on the basis of this interpretation.</td>
<td>● Thinking is a symbolic process whereby the individual selects a course of action based on an assessment of the alternatives.</td>
<td>● Humans are active participants in what they do.</td>
</tr>
<tr>
<td>6</td>
<td>● Joint action is formed through the linkage of the lines of action of its participants.</td>
<td></td>
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</table>

Table 3.1: Key concepts in Symbolic Interactionism
Symbols are central to symbolic interactionism. Charon (2004:47) views symbols as a type of social object. A social object becomes a symbol when it is used intentionally to “communicate and represent” (Charon, 2004:47). It is “a stimulus that has a learned meaning and value” (Rose, 1962:5). In symbolic interactionism humans are seen as living in a symbolic world in which almost all the symbols are learnt through interaction with others. Language is viewed as the most important type of symbol as it is through this that other symbols can be interpreted (Charon, 2004:52).

The importance of symbols cannot be underestimated as they replace physical reality with a socially created one, they form the basis of human society and they are central to individual life. The challenge for me was to relate these concepts to my study. I reconciled this from a number of angles:

- through the process of the social interaction between the physiotherapist and their patient, each participant will have defined what PCC care means to them through the creation of symbols;
- in SI, thinking is considered as a constant process of self-communication, whereby reality is modified. It may involve deliberation when more complex problems or situations are encountered. My perception was through the interview process itself; the individual therapist and myself as the researcher would modify their pre-existing perceptions;
- I, as the researcher possess a self, an object to myself. I am defined by how others see me: a physiotherapist; lecturer; student; white; middle-class; wife; mother and daughter. To the research participants I could be defined as an outsider; a researcher; an expert; a colleague or an examiner, and this would influence their social interaction with me;
- the ability to take the role of another, to see another’s perspective, to use their symbolic framework is integral to human interaction. The challenge for me would be to put aside my own perspectives, not judge and to be open to changing my own perceptions of PCC;
another facet of role taking is that of “generalised others” (Charon, 2004:110). In addition to the personal meaning of PCC care for the individual physiotherapist, I also had to consider other influences. The perceptions of the participants would be influenced by their professional group, physiotherapy and in particular musculoskeletal physiotherapy, and the specific physiotherapy department in which they operated. The term “reference group” has been used to refer to the group whose perspective an individual uses (Shibutani, 1962:132). The physiotherapists would have learned that perspective and would apply it to their definition of PCC;

finally, in SI it is considered that individuals act towards a specific goal, through a “stream” (Charon, 2004:116) or “line of action” (Blumer, 1969:15). However, decisions are influenced by social interaction and definition. The actions of individuals may influence each other so that plans may be revised, amended or replaced. In this way action is seen as taking place in the present. In the context of my study, the participants’ goal of physiotherapy for patients with back pain would need to be ascertained and the factors influencing its realisation would require exploration.

SI has a dual role as a theory of human behaviour and an approach to enquiry (Goulding, 2002:41). It is suggested however that studies undertaken within the paradigm made little reference to the techniques of analysis. Glaser and Strauss (1967) addressed this limitation by developing a more systematic method of data collection, analysis and verification. In relating the philosophical basis to the methodology of grounded theory, Corbin and Strauss (2008:8) state quite simply that “the world is very complex” and to capture as much of the complexity as possible requires a complex methodology. The authors suggested that the concepts formed through the analytical process help to provide shared understandings, a language for discussion. They summed this up succinctly in the statement “if you don’t have a language, you can’t talk – and if you can’t talk, you can’t do, and the basis of many professions is still doing” (Corbin & Strauss, 2008:8).
3.4 Grounded Theory as a Methodology

GT was developed by Glaser and Strauss (1967) during their study of dying in hospitals. In response to the prevailing view in the 1960’s that qualitative research was unscientific, they proposed systematic strategies for qualitative analysis that could generate theory, in particular “abstract theoretical explanations of social processes” (Charmaz, 2006:5). Their book “The Discovery of Grounded Theory” afforded qualitative research “scientific respectability” (Smith & Biley, 1993:355).

3.4.1 Assumptions of GT

The key assumptions underpinning GT provide support for its relevance to my study. The first assumption is that people make sense of their world even though this may not be apparent to observers (Hutchinson, 1993:185). This suggests that individuals sharing common circumstances, in this study musculoskeletal physiotherapists treating patients with LBP, experience shared meanings and behaviours. Secondly in GT there is the assumption that each group shares a specific “social psychological problem” that is not necessarily articulated (Hutchinson, 1993:185). For the therapists in my study this could be related to a lack of appreciation of a patient-centred approach and as such this resonated with my original “disturbance in practice”. By exposing and conceptualising the social psychological problem it is then possible to explain and predict behaviour. Reflecting its theoretical perspective, GT focuses on interactional processes from the perspective of the participants. Through a series of analytical steps it attempts to develop a theoretical conceptualisation of the social processes being studied (Smith & Biley, 1993). It is this theory generation that delineates GT from other forms of qualitative research. It allows for the development of a “conceptual framework from the data” rather than from previous studies (Clark, 1995:587). The process of theory development involves a system of analytic steps that goes beyond a simple description of a situation.

3.4.2 Theory development

The process by which the theory is developed has been the topic of considerable debate. Following their discovery of GT, Glaser and Strauss adopted divergent paths
in further developing the methodology. Glaser continued to stress the “interpretive, contextual and emergent” nature of theory development (Goulding, 2002:47), whilst Strauss and his subsequent collaborator Corbin, developed a highly complex process of systematic coding (Strauss & Corbin, 1990). The “emergence versus forcing” debate surrounding theory generation continues unabated and has stimulated a considerable amount of discussion in the literature (Boychuk Duchscher & Morgan, 2004). In a detailed exploration of the two approaches, Walker and Myrick (2006) argued that superficially there were no recognisable differences as both used similar processes; the differences lay in how the processes were carried out. However, before exploring the “grounded theory debate”, it is worth considering other aspects of the two approaches in terms of their commonalities and differences.

3.4.3 A comparison of the Glaser and Strauss and Corbin approaches

i. Commonalities
The features common to both approaches are outlined in Table 3.2 along with a consideration of the implications for my study. The goal in both approaches is the development of a theory; not the testing of a pre-existing one. The theory is therefore “grounded” in the data. As discussed, the concept of “emergence” is a disputed one. In this study the term “emerging” refers to the simultaneous process of data collection and analysis, whereby the developing theory is continually refined through the application of the analytical techniques of GT (Birks & Mills, 2011: 20).

ii. Differences

- Use of literature
The role of literature in GT has attracted some debate. Glaser (2004) suggested that a literature review should not be undertaken until the final stages of analysis, whilst Strauss and Corbin (1990:50) considered that researchers should acknowledge the influence of prior work. Overall, there appears to be a consensus that a comprehensive review of the literature should be avoided prior to the study. This is to avoid researchers becoming “so steeped in the literature that he or she is constrained or even stifled by it” (Corbin & Strauss, 2008:36)
<table>
<thead>
<tr>
<th>Feature</th>
<th>Characteristics</th>
<th>Implications</th>
</tr>
</thead>
</table>
| Theoretical sensitivity | • The ability of the researcher to understand, give meaning to the data and develop a theory. | • The researcher should enter the setting with as few pre-determined ideas as possible.  
• The researcher has to maintain distance, tolerate ambiguity, remain open, develop theoretical insight and await the emergence of the concepts. |
| Theoretical sampling    | • Initial sampling is purposive, using pre-determined criteria. Subsequent sampling is based on the emerging theory.  
• New data is collected and analysed to extend the categories until theoretical saturation is achieved. | • Quality rather than quantity of the data is important.  
• Attaining theoretical saturation is facilitated when the research question is clearly defined and the sample is restrictive. |
| Constant comparative analysis | • In each stage of the analysis, comparisons are made within and between data, categories and concepts to generate a theory with sufficient detail and abstraction. | • Data collection and analysis take place simultaneously.  
• Data from initial interviews inform subsequent questioning. |
| Literature review       | • Extensive reading in the area should be avoided until the emergence of the core category. This ensures the theory emerges from the data not from pre-existing theory (Glaser, 2004).  
• The researcher will come to the study with some knowledge of the literature and this should be acknowledged (Strauss and Corbin, 1990). | • General reading takes place so the researcher approaches the study with some background knowledge.  
• The literature review takes place during and after data collection. |
| Theoretical memos       | • Informal analytical notes which capture thoughts, ideas, comparisons, connections and directions to pursue. | • Memo writing takes place throughout the research process.  
• Early memos explore and expand the codes and direct data collection.  
• Advanced memos describe the emerging categories, demonstrate connections between them, make comparisons, identify gaps and build into chapters. |

Table 3.2: Common features of the Glaser and Strauss and Corbin approaches to grounded theory
It is suggested however that an initial “limited and purposive” review can enhance the researcher’s sensitivity (Birks & Mills, 2011:22). It can orientate them to the area of study without biasing their interpretation of the data. Through the initial assignments in my doctoral studies and the requirements of the ethical process, I embarked upon the study with a strong background in the literature relating to PCC. Whilst this was unavoidable, it was important that I acknowledged the potential influence of this knowledge on the research process. It was perhaps fortunate that little was known about the concept of PCC in relation to physiotherapy when I started the study.

- **Memoing**
  With reference to memoing, Glaser (2004) emphasised its importance in conceptualising the data beyond a rich description. In contrast, it is suggested that Strauss and Corbin afford this process less importance, an approach criticised as “reductionistic and fragmented” as it may potentially decrease the process of conceptualisation of the data (Boychuk Duchscher & Morgan, 2004:610).

### 3.4.4 What constitutes a theory?

Theory development in GT may be substantive or formal. Formal theory relates to a study of phenomenon under several different situations; whereas substantive theory is focused on one specific area. The goal of my study of PCC in musculoskeletal practice was therefore the development of a substantive theory (McCann & Clark, 2003a). I admit to finding it somewhat problematic to envisage what a GT would look like. I was partly reassured, but also frustrated to learn that this appears to be characteristic of GT. Charmaz (2006:123) has suggested that “the term theory remains slippery in grounded theory”. An issue appears to be the extent to which a GT is considered to be explanatory. Drawing on an interpretivist and constructivist perspective, Charmaz (2006:126) emphasised “understanding” rather than explanation, recognising that the theory is an interpretation by the researcher. The definition by Stauss and Corbin (1998:15) appears more positivist in its focus. They defined it as “a set of well developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena”.

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The ability of the theory to explain and predict is as a result of the “high levels of abstraction” associated with GT (Birks & Mills, 2011:113).

Whilst there is a lack of consensus regarding the purpose of theory in GT, there is agreement regarding other aspects of the concept:

- it is associated with “theoretical conceptualisation” - the conceptualisation of the relationship between and across concepts (Goulding, 2002:45);
- it is concerned with patterns of action and interaction and hence process is a central feature (Charmaz, 2006:136; Goulding, 2002);
- it should go beyond descriptive analysis (Birks & Mills, 2011:113; Charmaz, 2006:137; Cutcliffe, 2005).

The final point has attracted considerable attention in the literature. It is suggested that many studies pertaining to be GT, do not rise above the level of description. Glaser (2004) has been particularly critical of this issue. The situation is attributed to final stages of the analysis where the researcher struggles with advanced coding and theoretical integration (Birks & Mills, 2011:113). Consequently the findings lack the required level of abstraction (Cutcliffe, 2005). The latter stages of analysis are recognised as the most demanding aspects of GT research (Birks & Mills, 2011:113). Theoretical conceptualisation requires abstract thinking and consequently it is a particular challenge for researchers who are more familiar and comfortable with the deductive processes associated with positivism (Hutchinson, 1993:209). This issue was one that concerned me a great deal and is revisited in my position as a researcher (Section 3.5).

3.4.5 **The grounded theory debate**

The GT debate surrounds the divergent paths adopted by Glaser and Strauss from their original collaboration. The most apparent difference between the two versions of GT appears to lie in the process of data analysis. This process has been summed up by Walker and Myrick (2006:548) as “a simple and complex, methodological and creative, rigorous and laissez-faire” process.
Whilst Walker and Myrick (2006:558) have suggested that the process for Strauss is more scientific and for Glaser more artistic, Boychuk Duchscher and Morgan (2004:609) have argued that the differences between the two are distinctive and irreconcilable. Central to the approach by Glaser (2004) was the focus on emergence of theory and conceptualisation of the data. The process appeared to be an intuitive one, a method of discovery where the researcher is a patient listener who waits for the theory to emerge (Boychuk Duchscher & Morgan, 2004). According to Glaser (2004), the researcher “must pace himself, exercise patience and accept nothing until something happens, as it surely does”. In contrast, Strauss and Corbin (1998) employed a series of methodological steps which have been criticised for being overly prescriptive and forcing the data into preconceived categories. It has been argued that this is not just a different version of GT but a completely different method that results in a full contextual description (Cutcliffe, 2005). Such a description falls short of conceptual theory generation.

In GT the primary intervention into the data is coding. Whilst coding is common to both approaches, it has been presented differently (Walker & Myrick, 2006) (Table 3.3). Glaser (2004) divided coding into two phases; substantive and theoretical. In substantive coding the focus was on producing categories and their properties, whereas theoretical coding occurred at a more conceptual level, relating the substantive codes to each other as hypotheses and integrating them into a theory. According to Glaser (2004) such codes provided “integrative scope, broad pictures and a new perspective”. Strauss and Corbin (1998) divided coding into three phases, open, axial and selective, each of which is associated with complex and detailed procedures. Integral to their approach in the open phase of coding was the identification of the properties and dimensions of the emerging categories and the use of specific analytical tools to assist theoretical sensitivity of the researcher (Strauss & Corbin, 1998:116). Although Glaser (2004) incorporated dimensionalisation of the categories, this was left until the later stage of theoretical coding and then only as one of a number of options. He viewed the level of intervention by Strauss and Corbin in the early stages as excessive, as it risked imposing pre-conceived frameworks on the data.
<table>
<thead>
<tr>
<th>Coding</th>
<th>Glaser</th>
<th>Strauss and Corbin</th>
<th>Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Conceptualisation of the data</td>
<td>Process of analysing the data</td>
<td>Straussarian approach is a more technical process</td>
</tr>
<tr>
<td>Method</td>
<td>Emergence of a theory emphasising constant comparison</td>
<td>Verification using tools, paradigms and matrices</td>
<td></td>
</tr>
</tbody>
</table>
| Phases | • Substantive  
  • Open  
  • Selective  
  • Theoretical | • Open  
  • Axial  
  • Selective | • Two as compared with 3 phases  
  • Glaserian step of theoretical sorting is not included in the process but is considered key |
| Phase 1 | **Substantive – open**  
Producing categories and their properties through line by line analysis & immersion in the data  
**Substantive – selective**  
Selective coding around a core category | Open  
Identification of categories/concepts and their properties & dimensions through specific analytic tools | • Key difference is the reference to dimensions  
• Greater level of intervention in Straussarian approach |
| Phase 2 | **Axial**  
Fractured data is reconstructed through the use of a coding paradigm.  
Relationship between categories & sub-categories is explored. | | • Glaserian approach does not support axial coding, criticising it as full conceptual description  
• It is central to the Straussarian approach |
| Phase 3 | **Theoretical**  
Occurs at conceptual level  
• Weaving substantive codes together into a hypothesis and theory | **Selective**  
• Occurs at a more abstract level than axial coding  
• A core category is selected, all other categories are related to it and other categories | • Phases are not directly comparable |

Table 3.3: A comparison of the coding processes in grounded theory (adapted from Walker & Myrick, 2006)
In the phase of axial coding the emphasis is on understanding the relationship and make connections between categories and sub-categories using a coding paradigm (Strauss & Corbin, 1998:127). Whilst this is central to the analysis by Strauss and Corbin (1998), it is not supported by Glaser (2004). Walker and Myrick (2006) have suggested that although the paradigm imposes a position on the data, it also provides clarity on how to make connections and integrate the categories and sub-categories. In the final phase of analysis the emphasis is on theory development. This is achieved through theoretical coding by Glaser (2004) and selective coding by Strauss and Corbin (1998:143). Walker and Myrick (2006) were ambivalent as to which approach was preferable. They indicated that the issue was perhaps the timing of the interventions which makes a direct comparison problematic (Table 3.4).

<table>
<thead>
<tr>
<th></th>
<th>Glaser</th>
<th>Strauss and Corbin</th>
</tr>
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<tbody>
<tr>
<td><strong>Substantive coding</strong></td>
<td>Fracture and select</td>
<td>Open coding</td>
</tr>
<tr>
<td></td>
<td>Fracture</td>
<td>Fracture</td>
</tr>
<tr>
<td><strong>Axial coding</strong></td>
<td></td>
<td>Axial coding</td>
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<td></td>
<td>Relate and integrate</td>
<td>Relate and integrate</td>
</tr>
<tr>
<td><strong>Theoretical coding</strong></td>
<td>Relate and integrate</td>
<td>Selective coding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Select and integrate</td>
</tr>
</tbody>
</table>

Table 3.4: Phases of coding in grounded theory

The final concepts to consider in the GT debate are that of the “core category” or “core variable” or “central category” and basic social psychological processes (BSPPs). The core category has been defined as “the central phenomenon around which all the other categories are integrated” (Strauss & Corbin, 1990:166). It is at the centre of the theory and should be capable of explaining most of the variation in the data (Glaser, 2004; Hutchinson, 1993:191; Strauss & Corbin, 1998:146). The discovery of the core variable is considered to be essential to the rigour of the final theory (Hutchinson, 1993:193). The difference between two analytical approaches is again evident in the timing of the selection of the core category. It can emerge either during open coding (Glaser, 2004) or selective coding (Strauss & Corbin, 1998:146). Interestingly Charmaz (2006:148) placed
less emphasis on the core category. For her the focus was on the inter-relationships of the categories and sub-categories which are integrated into a narrative.

Reflecting the assumption of GT that groups share a specific “social psychological problem” (Hutchinson, 1993:185), the identification of a BSPP is an important concept in GT. Cutcliffe (2005) has suggested that the core category should explain how the participants resolve their problem. Hutchinson (1993:193) indicated that BSPPs are core variables that demonstrate social processes as they progress over time. In slight contrast, Glaser (2004) suggested that the core variable can be any kind of theoretical code, not just a process. Whilst this is echoed by Strauss and Corbin (1990:123), they do stress that the core category should reflect the fact that grounded theory is “an action orientated model”.

3.5 My position as a researcher

It is suggested that three factors impact upon the quality of a ground theory study (Birks & Mills, 2011:33) (Figure 3.3). As the goal of any research is a credible outcome, these considerations provided a useful framework for an exploration of my position as a researcher. In addition the concepts of reflexivity and theoretical sensitivity are discussed in relation to my study.

![Figure 3.3: Factors influencing quality in GT research (Birks & Mills, 2011:34)](image-url)
3.5.1 **Researcher expertise**

Birks and Mills (2011:34) have suggested that a doctorate can be viewed as a “research apprenticeship” and as such many students will embark on a GT study with little or no experience of the methodology. Consequently they recommended that students should increase their knowledge and understanding of the philosophy and techniques of GT. In considering the most appropriate methodology for my research question, I initially considered GT and dismissed it as far too complex. My experience reflected the comment by Walker and Myrick (2006:547) who suggested that the methodology is “frequently discussed, debated and disputed”. In revisiting GT, I invested considerable time in familiarising myself with its background, theoretical basis, development and divergent paths. Despite this, I still had a number of anxieties regarding my ability and competence to undertake this approach. The main concern was that my background and experience did not equip me with the requisite skills to act as both an inductive and deductive thinker and to attain the level of abstract thinking required to generate a conceptual framework. As previously discussed, criticism has been levelled at a number of GT studies that have generated descriptive theories that lack depth and this served to fuel my anxieties.

Whilst my expertise in GT was limited, I recognised that I did bring other skills to the study. These included the knowledge and experience acquired through my roles as a clinician, lecturer and manager. As such, I possessed a number of generic skills that would assist me in undertaking the study. Corbin and Strauss (2008:305) have also identified a number of personal attributes of the researcher including self-awareness, sensitivity for the topic being studied and a commitment to hard work. I felt that these were qualities I could also bring to the study.

3.5.2 **Methodological congruence**

Methodological congruence is considered to occur when there is harmony between:

- the personal philosophical position of the researcher;
- the aims of the research;
- the methodological approach selected to address the aims (Birks & Mills, 2011:36).
Prior to my doctoral studies I was completely unaware of my own philosophical position. It was a concept with which I was unfamiliar and hence had not considered. An exploration of my assumptions about the world and how we attain knowledge about it was challenging, particularly in relation to the complexity of the concepts and language involved. As discussed in relation to epistemology and ontology (section 3.2), I began to recognise that my own philosophical position as a “positivist” was influenced by my training as a physiotherapist, my subsequent clinical experience, post-qualifying education and role as a researcher on a large RCT. As a result of the early assignments in my doctorate, I became increasingly aware of the fallibility of research undertaken in the positivist paradigm and the incompatibility of the approach to address my question. I recognised a shift in my perspective and a growing appreciation of the value of interpretivism. In adopting a constructionist stance for my study I was rejecting the notion that data was real and that I was going to discover a theory from it. Instead the findings from my study would be based on my personal interpretations of the participant’s accounts of their realities. I would be theorising the interpretations of the research participants and the resulting theory of PCC would also be an interpretation. The knowledge generated as a result of my study would be a product of the interactions between myself as the researcher and the participants.

Despite my increasing familiarity with GT as a methodology, I was still uncertain as to which approach to adopt – that of Glaser or Strauss and Corbin. Some authors have suggested that as the two versions represent distinct philosophical paradigms, researchers need to be clear and explicit as to which they are adopting (Boychuk Duchscher & Morgan, 2004; McCann & Clark, 2003a; Smith & Biley, 1993). In contrast, others have suggested a more pragmatic approach drawing on elements of both versions (Kennedy & Lingard, 2006). Indeed Eaves (2001:662) urged researchers to draw on both approaches to “argue for, advocate, and defend your own position”. Whilst I recognised that this was perhaps the most pragmatic approach, attempts to combine the two approaches have been questioned (Boychuk Duchscher & Morgan, 2004). Additionally, as a novice qualitative researcher and grounded theorist I lacked the experience and confidence to determine my own stance. In terms of its philosophical basis and structured approach to analysis, the approach by Strauss and Corbin (1998) held
the most appeal. Although I appreciated that their prescriptive tools may potentially “befuddle researchers rather than escort them” (Boychuk Duchscher & Morgan, 2004:608), I was encouraged by Charmaz (2006:9) who suggested that researchers can adapt the guidelines for their own studies.

### 3.5.3 Procedural precision

Procedural precision refers to the careful application of GT methods (Birks & Mills, 2011:37). It involves maintaining an audit trail to provide a transparent account of the decisions made throughout the process, establishing a structured mechanism for managing the data and ensuring that analytical developments are grounded in the original data. Procedural precision is enhanced through the process of memoing. This is considered as integral to GT (Table 3.2). Glaser (2004) defined memoing as “theoretical notes about the data and the conceptual connections between categories”. It is proposed that memoing is the most effective means of conceptualising the data and formulating a theory (Birks & Mills, 2011:41). In terms of my role as a researcher, I recognised that memoing would be a challenge for me. The diligence and discipline required to maintain a clear record of my thought processes was not familiar practice.

### 3.5.4 Reflexivity

Reflexivity refers to the researchers’ own self-awareness and critical analysis of their research experience and is generally considered to be integral to qualitative research (Avis, 2005:6). Interestingly, early GT works did not refer to the concept (Birks & Mills, 2011:53). Whilst acknowledging its role in their latest book, Corbin and Strauss (2008:31) indicated that the individual researcher should determine the extent to which they adopt a reflexive stance. In contrast, Charmaz (2006:149) has emphasised that researchers are part of the theories they construct and hence reflexivity was essential.

The concept of reflexivity is closely related to the concept of “self” (Section 3.2). The self is an object which emerges from a process of social interaction in which other people define the individual (Charon, 2004:91). In addition to acting toward objects in their environment, the individual can be an object of their own action. The self enables the individual to engage in a social interaction with themselves.
and by doing this the individual is changed (Blumer, 1969:13; Charon, 2004:93). Additionally it is suggested that each individual has a number of reference groups whose perspectives they use as “frames of reference” (Shibutani, 1962:132). As such they have multiple perspectives of “self” (Birks & Mills, 2011:55). In relation to my study, I recognised that I was the architect of the research, inextricably linked to it from start to finish. I was not an objective unbiased observer. Instead I possessed multiple perspectives which would consciously or sub-consciously influence my interpretations throughout the study.

### 3.5.5 Theoretical sensitivity

In contrast to the limited support for reflexivity in the seminal texts of GT, the importance of theoretical sensitivity appears to attract agreement (Table 3.2). It is interesting to note however that the centrality of the concept appears to have waned in the writings of Strauss and Corbin. In their initial work (Strauss & Corbin, 1990:41), a complete chapter was devoted to the concept. In subsequent editions, it was considered as “sensitivity” in contrast to “objectivity” (Corbin & Strauss, 2008:32; Strauss & Corbin, 1998:42). Whilst considered as integral to the development of GT, it is also suggested that it is “intangible” in nature (Birks & Mills, 2011:58). Strauss and Corbin (1990:46) defined it as “the ability to recognise what is important in the data and to give it meaning”. Birks and Mills (2011:58) have suggested that it has three features:

- it is the sum of the researchers personal, professional and experiential history;
- it can be enhanced through the use of specific techniques;
- it increases as the research study progresses through immersion in the data and reflexivity.

It is also recognised that theoretical sensitivity can be enhanced through knowledge of the literature in the area of study and as discussed in Section 3.4.3, this is another area of controversy in GT.

### 3.5.6 My personal position

It is suggested that researchers should identify the characteristics of their multiple selves prior to embarking on their research (Birks & Mills, 2011:59). I recognised that all my prior personal and professional experiences would contribute to my
position as a researcher and that it was important to be explicit about the potential influence of these experiences at the outset of the study. My self-awareness and insight into my own personal stance as a researcher was facilitated by considering where I was situated on the “insider-outsider continua” (Hellawell, 2006).

- I had worked in the NHS and specifically within musculoskeletal departments for many years. This provided me with an intimate knowledge of the working practices and “culture” of this environment. Whilst this placed me as an “insider”, I have not practiced clinically for a number of years and had not specifically worked in the department in which the study was conducted. Consequently I was also an “outsider” to the participants and to current working practices.
- I have worked in Education for the last 12 years. I was therefore an “outsider” in a role that was potentially intimidating to the participants. However, the department in which the study was conducted has strong links with my University. Students undertake placements at the Hospital and the Superintendent Physiotherapist is closely involved in developments within the undergraduate curricula. The links between the two organisations meant that my presence within the department was not seen as unusual.
- As a physiotherapist who specialised in musculoskeletal physiotherapy I had a similar background to the participants placing me as an “insider”. However, the adoption of a biopsychosocial approach to back pain was in its infancy when I left clinical practice. This placed me as an “outsider” in terms of current clinical practice.
- I was undertaking a qualitative study using a methodology with which I was unfamiliar. Despite embracing its philosophical basis, I had grown up as a positivist. I was an “outsider” to this form of research. I recognised that my approach to the data analysis was likely to be clinical and objective and that conceptualisation of the data would be particularly challenging.

Finally, in positioning myself as a researcher I had to reflect on my own perspective of PCC. I was advised to consider this issue in the feedback from one of the early assignments in my doctoral studies. At the time I regarded this as an unusual comment, as my entire rationale for the study was to explore the concept. I subsequently recognised that as my pre-conceptions could potentially influence
the entire study and its findings, it was an important exercise. When I was first exposed to the term PCC, my reaction was that, as a concept, it should be unnecessary. Physiotherapy is by definition patient-centred. The initial assessment, including its subjective interview and physical examination, and all subsequent treatments and management are centred on the individual patient. My perception was that, if asked, every physiotherapist would claim that the patient is central to what they do. However, as a result of my “disturbance” in practice (Section 2.2) that conviction was challenged. Consequently, I embarked upon the study in a state of expectancy, unsure of what I would uncover.

3.6 Method

This section details my justification for the method of data collection I adopted for the study. In particular it highlights the congruence between my philosophical position, grounded theory and the chosen method of data collection.

3.6.1 Selection of method

The method I selected to gather the data was that of interviews. It is suggested that qualitative interpretive research requires the researcher to enter the participants’ worlds, and that “rich, substantial and relevant” data is key to the development of a credible theory (Charmaz, 2006:18). Glaser (2004) has argued that “all is data”. Potential sources can include organizational charts, patient records, policies, media coverage, fiction and anecdotal descriptions, however observation and interviewing are recognised as the foundation of GT data (Hutchinson, 1993:188) and indeed may complement each other (Charmaz, 2006: 28). My choice of interviews over observation was influenced by a number of considerations:

- the role of the observer is to “look, listen and record” and as such it did not fulfil the aim of my study to explore perceptions (Silverman, 2006: 67);
- the potential exists for the researcher to give meanings to the actions and interactions they observe, without the involvement of the participant, resulting in misinterpretation (Corbin & Strauss, 2008: 30);
- observation involves prolonged engagement with the participants and as such was not a practical option of data collection for me;
finally, and probably most importantly, my interest in the topic and subsequent research question partly arose from my observations of patient-therapist interactions (Section 2.2). Consequently, I did not consider that additional observation, albeit from a research perspective, would provide the data required to address the question.

My selection of interviews as a method of data collection was also influenced by its congruence with my philosophical position:

- in adopting a relativist ontological perspective, I recognised that meaning is created by the individual's interactions with the world;
- my epistemological perspective of constructionism indicated that the most appropriate means by which I could explore the participants' meanings was to talk to them in an interview setting (Mason, 1996:40);
- I considered that the concept of PCC was complex and highly individualised. This necessitated a flexible method of data collection which could be tailored to the individual participant. Interviews provided the opportunity to pursue issues raised by the participants rather than being constrained by pre-determined questions as in questionnaires or formal interviews;
- in SI the meaning of objects is defined through social interaction both between individuals and the thinking within the individual. Interviews enabled an exploration of the symbolic meaning of PCC to the individual participant. The thought processes stimulated by the interview served to potentially modify or change pre-existing perceptions;
- finally, interviews allowed for myself, as the researcher, to be part of the construction of a plausible GT. As previously discussed, I was not a neutral observer but intimately involved in the whole process from the generation of the question through to the final theoretical integration and development of the theory. As stated succinctly by Kvale (1996:2) “the qualitative research interview is a construction site of knowledge”.

3.6.2 Type of interview

Interviews may take many different forms ranging from unstructured through partially-structured to highly-structured. It is argued however that even in the most
unstructured interviews, the researcher will have a sense of the topics and issues they wish to explore (Legard, Keegan, & Ward, 2003:141). Charmaz (2006:28) has suggested that “intensive interviewing” is particularly appropriate for GT studies. Within this form of interviewing, questioning can range from semi-structured questioning to a more generalised exploration. Whilst the intensive interview is considered as conversational, through probing and requesting more detail and clarification, the interviewer facilitates the participant to articulate their meanings (Charmaz, 2006:26). Consequently, the interviewer obtains a deeper understanding of the participant’s meanings. In considering the approach to adopt for my study, I was drawn to the intensive interview. My perception was that it would provide me with the combination of structure and flexibility, enabling me to remain responsive to the direction the participant wished to pursue.

3.7 Summary

In this chapter the methodology for the study has been presented and justified. GT was selected as the most appropriate and personally appealing methodological approach. The philosophical basis for GT has been discussed and the implications for my study considered. GT has attracted considerable attention in the literature partly due to the controversies surrounding its evolution. As a result of some deliberation, I decided to adopt the approach proposed by Strauss and Corbin (1998). As a novice researcher I perceived that this would provide me with the structure and detail I required to successfully complete the research. Interviews were considered to be the method of data collection most congruent to the research question, philosophical basis and methodology. Finally I considered my own position as a researcher prior to embarking on the study. I recognised that I was in some aspects an insider and in others an outsider and this would influence the way the participants viewed me and my interpretation of the data. I also acknowledged my own considerable limitations as a qualitative researcher at the start of the study.
Chapter 4
The Method

4.1 Introduction

In this chapter the operationalisation of the study is detailed. The chapter starts with an overview of the Trust in which the study was conducted. A comprehensive description of the research strategy is provided including: developmental work; ethical considerations; sampling; participant details; data collection, management and analysis. Issues relating to the rigour of the study are discussed. A reflection on the process of interviewing and an audit trail is included. As discussed in the Introduction, the plans for the study were modified mid-way and patients were not interviewed. This chapter reports on the modified study.

4.2 The venue for the study

The study was conducted in a National Health Service (NHS) Trust in Hertfordshire. The Trust was formed in 2000 following the merger of two smaller Trusts. It is one of the largest organisations in the area; employing around 4000 members of staff and serving a population of around 500,000. The Trust manages three hospitals; however the interviews were only undertaken in the largest of the three. The musculoskeletal physiotherapy out-patient service of the hospital receives referrals from general practitioners (GPs) and consultants from within the Trust for a variety of musculoskeletal, orthopaedic and rheumatological conditions. Additionally it is home to a Musculoskeletal Clinical Assessment and Treatment Service (MUSCAT). In this service all GP referrals to the orthopaedic and rheumatology clinics are triaged by a Consultant and specialist physiotherapist. If they are considered to be appropriate for physiotherapy, the patient is then assessed by the physiotherapist. Following the assessment the physiotherapist decides on the most appropriate management for the patient. This may include onward referral for further investigations, an orthopaedic or rheumatology opinion or physiotherapy.
4.3 Developmental work

Assignment three of my doctoral studies involved a small scale research project which was undertaken in June 2006. The main purpose of this project was to increase my proficiency in the use of interviews and to undertake a preliminary analysis of the data using grounded theory (GT) techniques. The study involved an exploration of the concept of patient-centred care (PCC) with three participants. This experience proved invaluable in developing my interviewing skills and familiarising myself with the analytical techniques. It is suggested that in GT there is an implicit assumption that researchers have a grounding in observations or interviews (McCann & Clark, 2003b). As a clinician and manager I was familiar with interviewing, however interviewing for the purposes of research proved to be a different experience. On reflection, I identified a number of limitations in my interviewing technique (Table 4.1).

<table>
<thead>
<tr>
<th>Use of narrow terms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent reiteration of what the participant said</td>
<td></td>
</tr>
<tr>
<td>Insufficient exploration of cues</td>
<td></td>
</tr>
<tr>
<td>Use of lengthy questions</td>
<td></td>
</tr>
<tr>
<td>Use of generalised questions</td>
<td></td>
</tr>
<tr>
<td>Suggesting concepts or words</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.1: Limitations of my interview technique in the developmental work

I subsequently explored the literature in relation to interviewing technique. A greater appreciation of the features of intensive interviewing (Table 4.2) and the interview situation (Kvale, 1996:124) (Table 4.3) proved helpful. Consequently, I embarked upon the interviews with greater confidence.

<table>
<thead>
<tr>
<th>Intensive interviewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go beneath the surface of the described experiences</td>
</tr>
<tr>
<td>Stop to explore a statement or topic</td>
</tr>
<tr>
<td>Request more detail or explanation</td>
</tr>
<tr>
<td>Ask about the participant’s thoughts feelings and actions</td>
</tr>
<tr>
<td>Keep the participant on the subject</td>
</tr>
<tr>
<td>Come back to an earlier point</td>
</tr>
<tr>
<td>Restate a point to check for accuracy</td>
</tr>
<tr>
<td>Determine the pace</td>
</tr>
<tr>
<td>Shift the topic</td>
</tr>
<tr>
<td>Validate the participants perspective</td>
</tr>
<tr>
<td>Use observational and social skills to further the discussion</td>
</tr>
</tbody>
</table>

Table 4.2: The features of intensive interviewing (Charmaz, 2006:26)
### The interview situation

| The interview conversation | • The interviewer must create an atmosphere in which the participant feels comfortable to discuss their views and experiences  
• Advance preparation is vital to the success of the interview |
| Framing the interview | • Prior to the interview brief the participant regarding the context of the interview  
• In the first few minutes, establish good contact through attentive listening, interest, understanding and respect for what the participant says  
• At the end of the interview, debrief the participant and invite them to add anything else they consider relevant  
• Allow some time after the interview to reflect on the interview and the interpersonal interaction between the interviewer and participant |
| The interview guide | • Ensure the interview questions promote a positive interaction to encourage the participant to discuss their views  
• Questions should aim to elicit the views and experiences of the participants rather than their speculations of why something occurred.  
• The primary questions should be in a descriptive form i.e. “what” and “how” questions rather than “why”. |
| The interview | • Key to the process is the interviewer’s ability to sense the immediate meaning and the numerous possible meanings in a response  
• Active listening may be more important than the actual technique of interviewing |

#### Table 4.3: The interview situation (Kvale, 1996)

To analyse the data from the small scale project, I adopted an approach devised by Eaves (2001). As a result of a comprehensive review of GT data analysis, Eaves (2001) identified a lack of clarity between various authors. As a novice researcher she wanted an approach that was clear, logical and sufficiently detailed to enable her to move through the various levels of analysis. She therefore devised a synthesis technique based on the work of other leading grounded theorists. Although I did not adopt the synthesis approach for the main study, opting instead for that of Strauss and Corbin (1998) (Section 3.5.2), the experience of coding was valuable. I found the analysis of the data to be considerably more time-consuming than I had envisaged. It was tempting to cut corners, and I found myself regularly losing concentration and focus. The time-
constraints of the assignment meant that I was not able to proceed beyond a basic analysis and I was left with some concerns regarding how I was going to handle the data in the main study. I was however reassured by Eaves (2001) who suggested that proficiency in GT is a circular process of learning, questioning and evaluating.

4.4 Ethical issues

In this section the process of ethical approval and the key ethical considerations for the study are described. The process for approval was lengthy, taking almost eight months. The reason for this was due in part to a lack of familiarity of qualitative research by the committee members.

4.4.1 Approval

The original plan for the study involved patients and participants who were employees of the NHS and as such, ethical approval had to be obtained from the Central Office for Research Ethics Committees (COREC). This was replaced by the National Research Ethics Service (NRES) in April 2007 and was subsequently incorporated into the Integrated Research Application System (IRAS) in September 2009. The ethics forms were submitted to the Hertfordshire Research Ethics Committee (REC) in May 2007. The committee meeting was held on 27th June 2007. I attended the meeting and was asked to clarify some minor issues. Additionally, some members of the panel indicated that the information sheet should provide examples of the types of questions that participants would be asked in the interview. In response, panel members familiar with qualitative research argued that this was perhaps inappropriate. Approval of the study was agreed, subject to some minor amendments:

- the participant information sheet should be written in accordance with the NRES guidelines;
- the Consent Form should be amended to reflect the fact that the patient’s General Practitioner did not need to be informed of their participation;
- the University of Brighton’s policy for the archiving of study data was clarified.

The required amendments were made and forwarded to the Committee (Appendix 1). Following these amendments final approval was obtained on 8th October 2007 (Appendix 2).
In addition to NRES approval, local Research and Development (R&D) approval was required. This was obtained from the Hertfordshire Hospitals R&D Consortium. Following submission of the forms the meeting of the committee took place on 26th November 2007. I attended the meeting but was only asked to respond to one question regarding the lack of a hypothesis for my study. This led to an interesting discussion among the panel members. Although verbal approval was obtained at the meeting, I was subsequently informed that as the panel were not experts in the field of qualitative research, the project had been sent for independent external review (Appendix 3). The result of the external review was received in January 2008 (Appendix 4). The reviewers made some interesting comments. In particular they wanted the topic to be situated in relation to current knowledge on PCC. I sent a detailed response to the review (Appendix 5) and the study finally received R&D approval on 7th February 2008 (Appendix 6).

As I was not an employee of the Trust in which the data was collected, I had to obtain an Honorary Contract which involved an application, Occupational Health Clearance and a Criminal Records Bureau (CRB) Disclosure. This proved a lengthy procedure due to some administrative delays. I finally obtained the contract with effect from 1st June 2008.

4.4.2 Ethical considerations

I considered that the key ethical issues for my study were: informed consent, confidentiality, anonymity and harm. These are defined in Table 4.4 and are now discussed in turn.

<table>
<thead>
<tr>
<th>Ethical issue</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed consent</td>
<td>“The voluntary and revocable agreement of a competent individual to participate in a research procedure, based on an adequate understanding of its nature, purpose and implications”.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>The way information obtained about others is treated.</td>
</tr>
<tr>
<td>Anonymity</td>
<td>The extent to which information is attributable to the interviewee.</td>
</tr>
<tr>
<td>Harm</td>
<td>Psychological harm may result from an exploration of the participants’ attitudes and beliefs – particularly if it exposes sensitive issues.</td>
</tr>
</tbody>
</table>

Table 4.4: Definitions of ethical terms (Sim & Wright, 2000:40)
i. **Informed consent**

My main concern when considering this issue was the potential for coercion. The Superintendent Physiotherapist of the Trust where the study was conducted was fully supportive of the study. She introduced it to the staff and arranged a time for me to present the study to the staff and invite them to participate. This may have created an atmosphere of expectancy in terms of volunteering. On reflection my perception is that this was not the case. The participants appeared enthusiastic about the study and willing to participate. A consideration however was that only staff with an interest in the topic volunteered. I was aware that some did not and clearly this is a consideration when interpreting the findings.

Whilst it has been argued that the process of seeking informed consent may influence the way participants interact (Sim & Wright, 2000:64), my own stance was that this was morally indefensible. Consequently I was diligent in ensuring that potential participants received all the relevant information relating to the study prior to making a decision to participate. The extent to which this approach enabled them to consider the topic and formulate their thought processes, even subconsciously, is impossible to predict. Prior to the interview they also had an opportunity to discuss the study. The purpose of the interview was reiterated and participants were invited to provide written consent.

ii. **Confidentiality**

Through the process of interviewing, information disclosed by the participants was entering the public domain. Consequently it was my responsibility as the researcher to explain to the participants what this meant for them and I discussed the process of data handling, transcription and analysis in some detail.

Whilst I did not perceive the topic of the research to be a “sensitive” subject; I had to be aware that issues relating to the organisation, management or other staff members may arise during the course of the interviews. In the event of such an occurrence I was aware that I would have to breach the confidentiality originally assured. I therefore made arrangements that participants would discuss their concerns with the Superintendent Physiotherapist in the first instance. The Head of the Acute Musculoskeletal Service was also available if additional support was
required. It is suggested that the moral integrity of the researcher is compromised if this is not made clear to participants prior to the research (Iphofen, 2005:30) and so the relevant information was included on the information sheet.

iii. **Anonymity**
Anonymity requires the protection of the identity of the participants in published works. It is suggested however that breaches of anonymity may occur inadvertently (Sim & Wright, 2000:66). This is a particular issue for qualitative studies where the sample sizes are small. Researchers are required to provide some descriptive details of their participants. Details such as gender and years of experience could easily identify a participant particularly if they all work in the same department. This was a pertinent issue for my study and one of which I had to be mindful when it came to dissemination.

iv. **Harm**
The concept of harm relates to the principles of non-maleficence (avoiding harm) and beneficence (doing good). The researcher has to achieve a balance between the two (Iphofen, 2005:19). In terms of my study, I had to consider the benefits that may result from the study balanced with the potential for the interview questions to cause emotional upset or embarrassment. In terms of the former, I was aware that there was no apparent benefit to the individual participants. However professionally I considered the topic an important one to address. Although I did not envisage that the participants would be disturbed by the interview questions, the possibility existed and as such I had to make appropriate arrangements to address the situation. Participants were assured that if they became unduly distressed the interview would be stopped and that they were free to withdraw at any time. In reality this was not an issue, however this may have been a different scenario if patients were involved.

4.5 **Sampling**
In GT two types of sampling are adopted: initial and theoretical. Whilst the former is common to all forms of qualitative research, the latter is unique to GT (Birks & Mills, 2011:69). Initial sampling occurs at the beginning of the study and involves
the identification of sampling criteria prior to data collection. The aim of theoretical sampling is to explain and develop the emerging categories. Both forms are purposeful in nature but with differing aims. Initial sampling involves identifying and collecting data from a source relevant to the study. Through analysis of that data the researcher becomes aware of issues that require clarification or further exploration. This is where theoretical sampling comes in. Birks and Mills (2011:69) have defined it as the “process of identifying and pursuing clues that arise during analysis in a GT study”. The timing of theoretical sampling has attracted some discussion. Whilst Charmaz (2006:103) has suggested that it is dependent upon the identification of categories, Birks and Mills (2011:70) argued that it should be adopted from the first data collection session; an approach that appears to reflect that of Corbin and Strauss (2008:57).

4.5.1 Initial sampling

Following ethical approval of the study I attended an in-service training meeting for the musculoskeletal staff in the Physiotherapy Department of the Hospital in June 2008. I prepared a short presentation which provided an overview of the study including its aims and the rationale for the research. The meeting was informal and friendly and the staff appeared genuinely interested in the project. I invited interested physiotherapists to contact me should they wish to participate and provided copies of the information sheet (Appendix 7). The criteria for inclusion in the study were:

- Chartered Physiotherapists working for the Musculoskeletal Service;
- Chartered Physiotherapists permanently based in an out-patient department. This was to ensure that the focus was on musculoskeletal physiotherapy.

At the end of the meeting, five of the staff approached me and gave me their contact details. All the volunteers met the study criteria and hence formed a purposive sample for the study. I agreed to contact them to make arrangements for the interviews.

4.5.2 Theoretical sampling

It is suggested that ideally data collection should be followed by analysis to inform the subsequent questioning (Birks & Mills, 2011:71; Corbin & Strauss, 2008:145).
However it is recognised that in reality, this may not always be possible due to practical constraints. This reflected my own experience. I had a “window of opportunity” to collect data during the summer of 2008 and the first five interviews were undertaken over a period of a few weeks. It was not possible to have each interview transcribed and analysed prior to the subsequent interview. As such I had to rely on listening to the recordings and making notes of the emergent themes. Whilst this falls short of a full analysis, it is suggested that the principles of theoretical sampling can still be applied (Birks & Mills, 2011:71). My interview guide was continually modified in response to the concepts generated from my early analysis.

Following the first five interviews, I entered a period of concerted data analysis (Section 4.7). As a result of this I developed a number of categories, but the core category remained elusive. I therefore went back to the Department and undertook another four interviews. These interviews were conducted approximately seven months after the original interviews. Theoretical sampling at this stage involved more focused questioning to elaborate the categories and identify a core category.

4.6 Participants
In total nine physiotherapists participated in the study. There were five females and four males. The participants ranged in experience from 5-25 years (average 11 years) (Table 4.5). Three of the participants were clinical specialists with a dual role in the Muscat service and in the Physiotherapy Department.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Experience (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>F</td>
<td>6</td>
</tr>
<tr>
<td>2*</td>
<td>M</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>25</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>8.5</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>5</td>
</tr>
<tr>
<td>8*</td>
<td>F</td>
<td>23</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>5</td>
</tr>
</tbody>
</table>

*Clinical specialist

Table 4.5: Details of the participants
4.7 **Data collection**

This section details the interview guide, the procedure I adopted for the study and incorporates my reflection on the process of interviewing.

### 4.7.1 *The interview guide*

Intensive interviewing was adopted as the method of data collection. As discussed in Section 3.6.2, it is inevitable that the researcher enters the period of data collection with areas that they wish to explore. Whilst experienced researchers do not necessarily use an interview guide, it is acknowledged that novices require more structure (Charmaz, 2006:29). Although the developmental work had increased my level of confidence, I still considered a guide was required and indeed I had to provide this for Ethical approval. The interview guide for the small scale study was informed by my prior knowledge of the topic and the relevant literature. In light of my greater appreciation of interviewing technique, it was subsequently re-structured and modified. I included more open questions, more “how” and “what” questions and tried to invite the participants to draw on their personal experience (Appendix 8). In particular, I considered the first question relating to the participants’ philosophy of practice, as a useful opening question. Initially the guide proved a useful prop; however it was quickly confined to the background and never followed in its entirety. My experience is that it served to increase my confidence and maintain focus. It is suggested that the guide will evolve as the study progresses (Birks & Mills, 2011: 75). In the second round of interviews, the interview guide was modified substantially. Whilst the questions remained open, they were also more probing with the aim of developing the emerging categories (Appendix 9).

### 4.7.2 *Procedure*

- Following the staff meeting, arrangements for the first five interviews were made via e-mail with the individual participants and reception staff. This often proved a lengthy process due to our respective commitments and the availability of the room for the interview. I attached a copy of the information sheet (Appendix 7) for the study to ensure that the participant had an individual copy.

- Recruitment for the second group of four interviews was assisted by the Superintendent Physiotherapist who provided me with a list of physiotherapists
who were willing to participate in the study. I contacted the potential participants by e-mail and provided them with an information sheet. If their response indicated they were willing to proceed, arrangements were made for the interview.

- All the interviews were conducted in a private room in the Physiotherapy Department of the Trust. The only exception was interview five which took place in the staff office as the private room was unavailable. This interview was the only one that was interrupted by the arrival of another staff member. Whilst this was a distraction, overall my perception is that it did not affect the quality of the data collected.

- In preparing for the interviews, I compiled a folder of all the relevant documentation and equipment. I used a digital recorder to record the interviews, with a cassette recorder as back-up. This proved a useful strategy as I failed to set the digital recorder correctly for interview eight and would have lost the second half of the interview if it had not been for the cassette recorder.

- Prior to each interview, I arrived early to set up the room. I tried to keep the environment as informal as possible so the interview did not appear as an interrogation. I placed the chairs at an angle to each other and the recorders on a plinth next to my chair. Once the participant arrived, I tried to keep the atmosphere relaxed, sensing that the participants may have had some anxieties regarding the interview.

- At the beginning of the interview I explained the purpose of the interview and asked whether the participant had any questions they wished to ask me. I stated that confidentiality was assured and that their anonymity would be protected. I also reminded them that they were free to withdraw at any time. I then asked the participant to sign two consent forms (Appendix 10). I kept one copy and gave the other to the participant. The interview then commenced.

- The initial questions revolved around some contextual details including current position, years of experience and post-graduate/qualifying courses. This was considered useful in formulating subsequent questions and in getting the participant to talk about a subject matter with which they were familiar (Legard et al., 2003). The first main question was a broad, open question relating to the participant’s overall approach to their management of patients with LBP. This
question was introduced as it was felt that their philosophy of care would influence their entire interaction with their patients. It proved to be a key question in all interviews providing the foundation for subsequent questions.

- During the interview I attempted to guide the participant through the themes of the interview guide whilst pursuing unanticipated leads. I focused on listening attentively, seeking clarification where necessary. I tried to avoid filling silences and the use of long and leading questions. Towards the end of the interview I invited the participant to provide any additional information that had not already been covered in the questions. The recording was then stopped.

- At the end of the interview I asked the participants if they were willing to be interviewed again if necessary, and if they were willing to review the interview once it was transcribed. I thanked them for taking part and discussed the next stages in the progress of the study.

- Once the participant had left the room I spent a few minutes reflecting on the interview. I made some notes of my initial perceptions, the overall feel of the interview, what had gone well and what I needed to consider in the subsequent interview (Appendix 11).

- Once the interviews were transcribed, I sent them back to the participants along with a Certificate of Participation to include in their Continuing Professional Development (CPD) portfolios (Appendix 12). The concept of respondent validation of the data has attracted some discussion in the literature. Whilst it can be considered as means of establishing credibility and dependability, it can also be problematic. Participants may wish to change or amend the data presenting the researcher with moral dilemmas (Johnson & Waterfield, 2004). Additionally Kvale (1996:172) suggests that transcribed language may appear incoherent and confused such that the interviewee may withdraw consent to the use of their interview. This last issue was the key to my decision to seek respondent validation. It was a strategy by which I could ensure on-going consent from the participants. Interestingly I did not receive any comments back from the participants.
4.7.3 Reflection on the interview process

My experience of interviewing reflects the comment of Mason (1996:42) who describes it as “hard, creative, work”. The process was very time-consuming requiring careful planning and preparation. This was exacerbated by the fact that the interviews took place away from my own work-place and hence I was reliant on the cooperation of others. I found that interviewing was challenging both mentally and intellectually. I had to listen to what the participant was saying; consider what aspects to follow-up; decide how to phrase the next question; note non-verbal signals; maintain the pace of the interview and be mindful of the time available. Listening to the responses was vital so I could formulate the subsequent questions appropriately.

I recognise that my interviewing technique developed across the interviews. In the early interviews I used the strategy of restating what the participant said to good effect; however a number of my questions were too direct:

| Do you feel that active element is quite crucial? (Interview 1) |
| And do you feel comfortable exploring difficult issues with patients? (Interview 2) |

I gradually became more skilled at pursuing issues that I considered had not been adequately explored:

| You also mentioned that to you patient-centred care also meant giving patient’s choice. How do you incorporate patient choice into your management programme? (Interview 5) |

I also became more adept at probing as evidenced in this exchange in interview 8. By listening attentively and giving the participant time, I obtained important information regarding her strategies for managing a patient who did not wish to be involved in their care:

<table>
<thead>
<tr>
<th>I</th>
<th>Ok Erm..</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>I would say they’ve got to be very involved</td>
</tr>
<tr>
<td>I</td>
<td>What if you can’t get that involvement?</td>
</tr>
<tr>
<td>R</td>
<td>Erm, so you might be thinking about a patient who’s expecting me to cure them?</td>
</tr>
<tr>
<td>I</td>
<td>Mm</td>
</tr>
<tr>
<td>R</td>
<td>Right, so you might negotiate a little bit……</td>
</tr>
</tbody>
</table>

I = Interviewer; R = Respondent
4.8 Management and organisation of the data

Following the interviews the data was transcribed into a written format for analysis. I originally secured the services of one of the administrators at my University to undertake this task. Unfortunately, due to medical reasons, she was unable to continue with this after the first tape. I was subsequently recommended to a Transcription Service who proved very reliable. Despite using a service, I found a number of errors in the transcriptions, particularly in relation to the medical terminology. Consequently the transcripts were checked for accuracy before commencing the analysis.

Prior to undertaking the analysis, I was advised to use a computer programme specifically designed for qualitative data. A number of programmes have been developed. Through my University I have access to NVivo and hence this was the obvious choice. I attended a two day course to familiarise myself with the programme before embarking on the analysis. Concerns have been expressed that computer programmes can detract from theoretical sensitivity (Sim & Wright, 2000:157). However, my own experience was that in comparison to the analysis of the early interviews in the small scale project, the initial analysis was much more manageable. I did not use NVivo beyond the early stages of coding as I felt that my inexperience of the programme was impeding my progress.

4.9 Analysis and interpretation of the data

I broadly adopted the analytical process developed by Strauss and Corbin (1998) for the analysis, recognising that although it is reductionist and procedural, it also provides direction for novice researchers (Section 3.5.2). My grasp of the analysis was facilitated by referring to the diagrammatic representation devised by Eaves (2001) (Figure 4.1). As discussed in Section 3.4.4, coding is the principal intervention in GT. It has been described as the “pivotal link” between gathering the data and developing a theory to explain the data (Charmaz, 2006:46). NVivo, was used to assist with the initial coding and organisation of the data. The analytical steps I followed are now detailed.

- Line by line coding was the first step in the coding of the first interviews. This involved naming each line of the data to generate concepts. Whilst a laborious process, it is suggested that this step encourages researchers to remain open
to what is going on in the data and provides direction for further data collection (Charmaz, 2006:48; Strauss & Corbin, 1990:73). I found the guidance by Charmaz (2006:48) particularly helpful in this process. I attempted to keep the codes active and close to the data; to make the codes fit the data as opposed to forcing the data to fit the codes; to keep the codes short, simple and precise and to view the familiar in a different light. In terms of naming the codes, where possible I utilised “gerunds” as these are recommended to provide a sense of action (Charmaz, 2006: 49). If appropriate I also used “in-vivo codes”, which use the participants own words and consequently preserve their meanings (Charmaz, 2006: 55). In undertaking the initial coding, I compared data with data to look for similarities and differences, and this served to decrease the number of concepts that were being generated.

<table>
<thead>
<tr>
<th>Open coding</th>
<th>Axial coding</th>
<th>Selective coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line by line analysis</td>
<td>Causal conditions</td>
<td>Explicate story line</td>
</tr>
<tr>
<td>Concepts</td>
<td>Phenomenon</td>
<td>Core category</td>
</tr>
<tr>
<td>Categories</td>
<td>Context</td>
<td>Subsidiary categories</td>
</tr>
<tr>
<td>Subcategories</td>
<td>Intervening conditions</td>
<td>Paradigm</td>
</tr>
<tr>
<td>Properties</td>
<td>Action/interaction strategies</td>
<td>Relate categories at dimensional level</td>
</tr>
<tr>
<td>Dimensional range</td>
<td>Consequences</td>
<td>Validate categories against data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fill in categories</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensional range</th>
<th>Develop conceptual density</th>
</tr>
</thead>
</table>

**Figure 4.1:** Diagrammatic representation of the Strauss and Corbin analysis of grounded theory (Eaves, 2001)

- Following line by line coding the concepts were grouped in relation to phenomenon identified in the data; a process termed categorisation (Strauss & Corbin, 1990:61). Categories are more abstract than concepts and serve to explain larger sections of the data (Eaves, 2001). Once identified, categories

---

2 Gerunds are formed by adding “ing” to the noun form of a word. They describe an action, state or process (Encarta dictionary)
were then developed in terms of their properties and dimensions, a step considered by Strauss and Corbin (1990:70) to be integral to theory development. Properties refer to the characteristics or features of the category, which are further qualified in terms of location along a continuum.

- Axial coding was the next stage in the process. This is the strategy whereby the fragmented data is brought back together. It is facilitated through the use of an analytical tool termed a paradigm (Strauss & Corbin, 1998:128). It has been proposed that axial coding encourages systematic thinking enabling the analyst to relate the data together in intricate ways (Strauss & Corbin, 1990:99). Axial coding takes the analysis beyond properties and dimensions and focuses on various aspects of the phenomenon (Table 4.6).

<table>
<thead>
<tr>
<th>Process</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Causal conditions</td>
<td>These are the events or variables that lead to the occurrence or development of the phenomenon. There is rarely a single causal condition for a phenomenon.</td>
</tr>
<tr>
<td>Phenomenon</td>
<td>The central idea, event, happening. What the data is referring to.</td>
</tr>
<tr>
<td>Context</td>
<td>The particular set of conditions within which the action/interactional strategies are taken.</td>
</tr>
<tr>
<td>Intervening conditions</td>
<td>Broad and general conditions which impact on the action strategies they may be facilitating or constraining. May include: time, space, culture, economic status, career, or history.</td>
</tr>
<tr>
<td>Action/interaction strategies</td>
<td>The purposeful, goal-oriented activities that agents perform in response to the phenomenon and intervening conditions. They can be strategic or routine.</td>
</tr>
<tr>
<td>Consequences</td>
<td>These are the consequences of the action strategies, intended and unintended. They can be immediate or cumulative, foreseen or unforeseen.</td>
</tr>
</tbody>
</table>

Table 4.6: The process of axial coding (Strauss & Corbin, 1990:99)

Although the significance of action and interaction was stressed by Strauss and Corbin (1998:134), initially I failed to appreciate its importance. “Interaction” refers to the verbal and non-verbal activities that occur between individuals and within individuals. It may involve processes such as discussions, teaching, and self-reflection. “Actions” represents the “active, expressive, performance form of self” undertaken in relation to the phenomenon (Strauss & Corbin, 1990:164). Whilst considered separately in early versions of GT (Strauss & Corbin,
of the two appear to merge in later versions appearing in the texts as “actions/interactions” (Corbin & Strauss, 2008:128; Strauss & Corbin, 1998:89). Reflecting the symbolic interactionism basis for GT, actions and interactions may change as individuals give meanings to situations. Particularly pertinent to my study was the concept that actions and interactions can be strategic or routine (Strauss & Corbin, 1998:133). Strategic actions and interactions may be adopted to resolve an issue and hence they shape the phenomenon in some way. In contrast, routine actions and interactions serve to maintain a situation and may involve following protocols or policies. Strauss and Corbin (1998:134) have suggested that if actions and interactions are not in “alignment”, conflict may arise and the situation may break down. A grasp of this concept profoundly influenced the shaping of my theory.

I also found the concept of “context” challenging to appreciate and struggled to understand how the phenomenon could lead to the context. Strauss and Corbin (1990:99) admit however that their paradigm model is a simplified representation. In their latest work, “context” appears separate to the paradigm (Corbin & Strauss, 2008:88). It represents the issues, problems, situations, goals or events that may arise in people’s lives and to which they have to respond through some form of action or interaction. As the contextual conditions change, actions and interactions are adjusted accordingly. Context is therefore viewed as more structural and actions and interactions as processes that change over time. The latest edition of their work also simplifies the process of axial coding to three broad stages:

- the conditions or situation in which the phenomenon takes place;
- the actions or interactions of the people in response to what is happening;
- the results of action taken or inaction (Corbin & Strauss, 2008:89) (Table 4.6).

The extent to which axial coding assists or obstructs the development of a theory is the topic of some discussion (Charmaz, 2006:62), however I did not have the confidence to omit it in the initial phase of the analysis and applied it to several of the main categories I had identified.
The final stage in the development of a theory is termed selective coding (Section 3.4.4). This involves a final integration of the categories around a core category. Strauss and Corbin (1990:124) describe this as "the sun, standing in orderly systematic relationship to its planets". It is the central event to which the action and interaction strategies are aimed. It was here that I acknowledged I was finding it difficult to distance myself from the analysis enough to conceptualise the story and select a core category. I was advised to put my codes and analysis to one side and to "free think" about what was going on in the data. I therefore went back to the transcripts to interrogate the data with specific questions (Table 4.7). I wrote each question on a separate sheet of A3 paper and then looked at the transcripts for examples that reflected the questions. I wrote the quotes on post-it notes, placed them on the sheets of paper and moved them around if I subsequently found that they belonged on a different sheet. This process opened up my thinking and enabled me to look at the data in a different way. New categories emerged and I was able to develop the range of activities in each category. I wrote memos throughout and drew diagrams to try and make connections between the categories.

| What are the types of things that determine patient-centredness? |
| What process is occurring? |
| What influences are there at play? |
| How does the therapist act? |
| How does the process change? |
| What are the results? |

Table 4.7: Questions used to interrogate the data

Strauss and Corbin (1998:89) have suggested a number of tools that can be used to enhance the researcher’s analytical thinking. These include the flip-flop technique, systematic comparison of two or more phenomenon, far out comparisons and waving the red flag. Personally I found that asking questions of the data stimulated me to think much more creatively about the categories and their relationships to each other. By constantly going back to the data I was also ensuring that my developing theory was "grounded". Asking
questions of the data is central to coding in GT as it assists in the identification of actions and processes. On reflection I recognised that if I had been more questioning of the data earlier in the analysis, my theory would potentially have emerged sooner. However I was reassured by the fact that that open and axial coding occur simultaneously and the researcher alternates between the two (Strauss & Corbin, 1990:89).

- Following a period of extensive and intensive engagement with the data I reached the stage where a theory was emerging but the core category remained elusive and I had some gaps in the data. At this stage I returned to the physiotherapy department to undertake the additional four interviews (Section 4.4). Data obtained as a result of this theoretical sampling was not subjected to line by line coding. Instead, I looked at segments of data searching for evidence to develop my emerging categories, their properties, dimensions and relationships. I also looked for data that did not fit with my theory.

- One of the interviews conducted at this stage provided a vignette of the “ideal” patient scenario and enabled me to move to selective coding. To assist this process Strauss and Corbin (1990:120) have recommended the formulation of a story line, initially through description, but ultimately through conceptualisation. This involves either selecting one of the categories which appears sufficiently abstract to include everything in the story, or alternatively devising another which has then to be developed in terms of its properties. In their description of dimensional analysis, an alternative method used to generate a GT, Kools, McCarthy, Durham, & Robrecht (1996:319), suggested that the researcher should “audition” the various components of the phenomenon (termed dimensions) for the central dimension. Although I did not use dimensional analysis in its entirety, I found that this was a useful strategy. None of my existing categories possessed sufficient density to become the core category, so instead I was required to develop a new one. Increasing familiarity with the analytical process, particularly the conditional matrix (Strauss & Corbin, 1998:181), enabled me to integrate the various factors I had identified as influencing the core category.
• The conditional matrix is an analytic tool devised as extension of the paradigm to assist the researcher to “put all the various pieces together to represent an overall picture of what is going on” (Strauss & Corbin, 1998:183). It is depicted either as a series on concentric circles (Strauss & Corbin, 1990:163) or a spiral (Strauss & Corbin, 1998:184) with the phenomenon under investigation at the centre. The tool assisted me to focus on the key actions and interactions that occurred in relation to the phenomenon.

• The penultimate step in the analysis was theoretical integration to develop my substantive theory (Section 3.4.3). This involved selective coding: selecting the core category, relating it to the other categories and concepts from the analysis and refining it by ensuring it was grounded in the raw data. It is suggested that three factors are required for theoretical integration:
  o a core category;
  o theoretical saturation of the categories;
  o a bank of analytical memos (Birks & Mills, 2011:115).

The second round of interviews did not generate any new codes but served to refine my existing categories and enabled me to identify the core category. Consequently I felt confident that I had reached a stage where there was no need to collect any additional data. I also had copious memos, word documents on my computer that included quotes, questions and proposed links between concepts (Appendix 13 provides an example of an early memo).

A story-line is suggested as a useful analytical tool to assist the researcher at this stage of the analysis. Strauss and Corbin (1990:116) differentiated a story from a storyline. They defined the former “a descriptive narrative about the central phenomenon” and the latter as “the conceptualisation of the story. This is the core category”. I was advised at this stage to write the categories as this would assist the formulation of the theory. Identifying my story with just a brief paragraph was enormously helpful in clarifying my thought processes. I also found diagrams were invaluable in identifying the relationships between the concepts and categories. Through writing the categories the links between the categories were explicated and the theory slowly emerged. This lengthy process involved returning to the original data on a regular basis to validate the final theory.
The final stage in the analysis was theoretical coding. Strauss and Corbin (1998) did not explicitly refer to this process and hence I failed to recognise it prior to undertaking the analysis. Theoretical coding refers to the application of existing theoretical frameworks to enhance the “explanatory power” of the theory (Birks & Mills, 2011:125). It is suggested that the researcher does not apply external theory until after their own is developed to avoid the potential influence of a pre-conceived framework. Inadvertently I had avoided this trap. Where possible, the use of discipline specific theoretical frameworks is recommended (Birks & Mills, 2011:125). However physiotherapy has been described as “theory poor, lacking conceptual models and frameworks” (Jensen, 2004:97), hence I had to look at sources outside my profession. In terms of developing a theoretical explanation, Turner (1988:13) proposed a four stage process:

- define the social interaction;
- break down the basic social process into its constituent components;
- develop “analytical models” to provide a visual representation of the components and their relationships;
- formulate abstract laws to explain the relationships between the components.

I perceived that my core and sub-categories defined the social interaction and the process of axial coding had served to break down the process into smaller components. The next step was to develop analytical models and explain the relationships between them.

4.10 Trustworthiness of the study

The terms trustworthiness and rigour are frequently used interchangeably in relation to qualitative research. My understanding is that the former refers to the level of confidence the reader can have in the study, whilst the latter relates to the process by which this is achieved i.e. the use of exacting standards of data collection and analysis. In this section the criteria and strategies commonly used to assess and ensure that qualitative research is trustworthy are discussed and related to my study.
4.10.1 Criteria for assessing quality

It is suggested that the issue of “quality” in qualitative research is unresolved after a quarter of a century of debate (Rolfe, 2006). Positions vary between:

- the use of the same criteria as quantitative research;
- the use of a criteria specifically designed for qualitative research;
- the appropriateness of any predetermined criteria for judging qualitative research.

The middle position is one that is probably the most commonly adopted in published studies (e.g. Hills & Kitchen, 2007b; May, 2001) and the one with which I felt most comfortable. Four criteria of “trustworthiness” are proposed: credibility, transferability, dependability and confirmability (Table 4.8).

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>The constructed realities of the participants are presented as adequately as possible</td>
</tr>
<tr>
<td>Transferability</td>
<td>The ability to transfer the findings to other settings</td>
</tr>
<tr>
<td>Dependability (Auditability)</td>
<td>All changes in data collection, analysis and interpretation are made explicit throughout the research.</td>
</tr>
<tr>
<td>Confirmability</td>
<td>The process of analysis is clear and adequate and the conclusions are warranted by the data</td>
</tr>
</tbody>
</table>

Table 4.8: Criteria of trustworthiness

Five strategies are commonly used to ensure the trustworthiness of qualitative research: sampling; respondent validation; triangulation; audit trail and reflexivity (Johnson & Waterfield, 2004). Sampling, respondent validation and reflexivity have already been discussed and are revisited in the Final Discussion. Triangulation can be interpreted in a number of ways. It can refer to the examination of data collected from different sources or by different methods, it can relate to the analysis of the data by two or more researchers who subsequently compare their findings, or it can relate to peer review where the data analysis and interpretation is scrutinised to ensure the emerging themes are robust (Johnson & Waterfield, 2004). Triangulation will also be discussed in the Final discussion.

4.10.2 Audit trail

An audit trail is a description of the decisions that were taken during the study (Johnson & Waterfield, 2004). It should be in sufficient detail that it can be
followed by others. I maintained a detailed and reflexive audit trail throughout the study and this proved particularly valuable during the process of data analysis. The audit trail is now presented and culminates in the identification of the sub-categories and the core category. The theory evolved over many months, however for the purpose of clarity it is presented in phases (Table 4.9).

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Generation of concepts through line by line coding</td>
</tr>
<tr>
<td>2</td>
<td>Initial categorisation of the data</td>
</tr>
<tr>
<td>3</td>
<td>An individualised assessment process as central to PCC</td>
</tr>
<tr>
<td>4</td>
<td>Co-operative interaction</td>
</tr>
<tr>
<td>5</td>
<td>Congruence</td>
</tr>
<tr>
<td>6</td>
<td>Interactional Congruence</td>
</tr>
<tr>
<td>7</td>
<td>Engaging the patient</td>
</tr>
</tbody>
</table>

Table 4.9: Summary of the development of the theory

- **Phase 1:** Generation of concepts through line by line coding

The initial line by line coding generated 67 separate concepts. The most common codes are detailed in Table 4.10.

<table>
<thead>
<tr>
<th>Concept</th>
<th>Number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Constraining factors</td>
<td>103</td>
</tr>
<tr>
<td>2 Addressing psychosocial factors</td>
<td>82</td>
</tr>
<tr>
<td>3 Managing expectations</td>
<td>79</td>
</tr>
<tr>
<td>4 Informing the patient</td>
<td>66</td>
</tr>
<tr>
<td>5 Patients expectations</td>
<td>61</td>
</tr>
<tr>
<td>6 Assessing the patient</td>
<td>52</td>
</tr>
<tr>
<td>7 Encouraging exercise and self-management</td>
<td>40</td>
</tr>
<tr>
<td>8 Developing a relationship with the patient</td>
<td>35</td>
</tr>
<tr>
<td>9 Giving patient’s choice</td>
<td>34</td>
</tr>
<tr>
<td>10 Being experienced</td>
<td>32</td>
</tr>
<tr>
<td>11 Being the expert</td>
<td>31</td>
</tr>
<tr>
<td>12 Supporting junior staff</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 4.10: Most common codes from line by line coding

It was at this stage that my inexperience and lack of awareness of the intricacies of the coding process became apparent. I considered that as constraining factors was the most common concept, it was clearly integral to PCC and I set about exploring it in more depth. The second most common concept I labelled addressing psychosocial factors even though only one participant used the term.
Strauss and Corbin (1990:68) have warned against the use of “borrowed terms” which have their own inherent meanings and can introduce bias into the analysis. It became very evident that I had not succeeded in making the familiar new and my disciplinary background was stifling the analysis. I was advised to familiarise myself more closely with categorisation and axial coding and to apply this to the data. As a result of this stage of the analysis my theory started to evolve and this is now detailed.

- **Phase 2: Initial categorisation of the data**

The process of categorisation of the data resulted in the identification of six categories which appeared to revolve around a central theme of tailoring their approach to the individual; a category I termed “individualising care” (Figure 4.2).

![Figure 4.2: Initial categorisation of the data](image)

The early categories were subsequently explored for their properties and dimensions. As a result of continued engagement with the data, I recognised that I was focusing on topics rather than actions and processes. For example, the early category of *communicating with the patient* included the concepts of involving, explaining, listening, informing, negotiating, explaining and talking. I realised however that these were communication strategies by which the participants got the patient “on board” with a management plan. The therapists used the strategies to obtain information from the patient, to provide them with information, the
outcome of which was an agreed plan of management. Later the title of \textit{communicating with the patient} was altered to \textit{gaining/giving information}. I identified the therapist as a \textit{professional} as an early category. It became evident however that it did not have properties and dimensions and was instead a concept that permeated the entire process along with other attributes related to the therapist as a person and as a professional. It also became clear that by placing \textit{individualised care} at the centre of the other categories, I had fallen into the trap of premature closure by failing to propose a theory with sufficient density to account for all the variation in the data (Hutchinson, 1993).

- **Phase 3: An individualised assessment process as central to patient-centred care**

At this stage in the development of the theory, I identified the assessment of the patient as key to the process (Figure 4.3).

![The assessment process](image)

\textbf{Figure 4.3:} The assessment process as central to patient-centred care

The assessment is part of the professional remit of the therapist involving a combination of conveying and gathering information which I termed a “working discourse”. Gathering information involved questioning the patient, listening to their responses, picking up cues from the patient to tailor subsequent questioning. This process enabled the therapist to obtain the patient’s perception of their
problem. Conveying information involved the provision of information about the patient’s problem and the role of physiotherapy in their problem. As a result the therapists’ perceived that the patients’ understanding and awareness of their problem was increased and they were more realistic about the likely impact of physiotherapy on their problem. My interpretation was that PCC was about individualising/personalising the assessment process and this was achieved through developing a relationship with the patient.

At this stage my impression was that developing a relationship with the patient was still a central category, particularly when managing patients with chronic pain. It enabled the therapists to explore the often complex factors that may be contributing to patient symptoms. Whilst psychosocial factors was a common initial concept and an early category, I recognised that instead it was another aspect of the information obtained from the patient during the assessment process. The assessment process culminated in the negotiation of an agreed management plan between the therapist and patient. This involved a reconciliation of therapist goals and patient expectations. As a result the patient was “on-board” with the management plan, compliance was facilitated and outcomes were enhanced. I recognised that the process of agreeing a management plan required further exploration, particularly in relation to patient choice. At this stage my interpretation was that it was predominantly therapist-led. Through axial coding the role of the physiotherapist emerged as integral to this process. Two elements appeared to be key: interpersonal skills for developing and maintaining a relationship with the patient and professional skills particularly in terms of their experience and professional role.

At this stage of the analysis I recognised that I was “stuck”. The middle category of engaging the patient was most likely a consequence of the therapeutic relationship enabling the negotiation of a management plan. Whilst this model was more action orientated, demonstrating a process, I had not identified a basic social psychosocial problem, a core category eluded me and I had still not accounted for all the variation in the data.
• **Phase 4:** Co-operative interaction

The process of “free-thinking”, asking questions of the data and returning to the transcripts (Section 4.7) enabled me to move to another level of conceptualisation and a new theory started to emerge. In this version the core category was still elusive but my perception was that it involved a co-operative interaction between the therapist and the patient (Figure 4.4). The therapeutic relationship was renamed as the *therapeutic alliance* reflecting the fact it is temporary and purposeful. The *gaining and giving of information* was seen as fundamental to the negotiation of a management plan. The latter was renamed *agreeing goals*, a process that occurred through discussion, negotiation and compromise and culminated in the formulation of goals of management. The three interactions were situated in the context of the lack of knowledge and guidelines for managing LBP, in particular chronic pain. The two participants in the interaction brought to it their own attributes and characteristics. The therapist was also influenced by their own professional practice knowledge and expertise and initiatives introduced to address the resource issues within the NHS.

![Figure 4.4: Co-operative interaction](image)

• **Phase 5:** Congruence

Data obtained from the further interviews, in particular the vignette of an “ideal” patient scenario (Section 4.7), facilitated the process of selective coding and the
identification of a core category. A core category emerged when I identified that
the basic psychosocial problem (BPSP) for the participants was one of trying to
attain a “fit” between what they could offer the patient and the patient’s
expectations, attitudes and beliefs. I termed this BPSP striving for congruence.
Through the use of the story line and the conditional matrix I considered that the
actions and interactions of the physiotherapists all pertained to the attainment of
congruence. The central phenomenon that appeared broad enough to encompass
all the categories and influencing factors was therefore given the conceptual label
of congruence and this was placed at the centre of the conditional matrix (Figure
4.5). The individual therapist and patient were placed in the circle closest to the
actions/interactions. The theory was further refined through the integration of the
intervening conditions.

![Diagram](image)

**Figure 4.5: Congruence** (C = congruence; TA = therapeutic alliance; AG = agreeing
goals; GGI = gaining and giving information)

- **Phase six: Interactional congruence**

  Modifications to the theory occurred as the sub-categories were developed. When
it came to exploring the three sub-categories I perceived that it was not possible to
discuss these without referring to the individual patient and physiotherapist. I
considered that instead of simply influencing the core category, they were the core category. I perceived that PCC was about striving for congruence in the interactions between the patient and physiotherapist and consequently the core was re-named as *interactional congruence*. I also recognised that the influence of National policies was manifested at a local level and consequently I removed it as a separate intervening condition and combined it with departmental issues (Figure 4.6). Following the identification of a core category and sub-categories, I set about writing the findings section of the study. I focused initially on the characteristics of the patient and then on the physiotherapist. I then moved onto explore the sub-categories, relating them to the relevant literature.

![Interactional Congruence](image)

**Figure 4.6**: Interactional Congruence (IC = Interactional Congruence; TA = therapeutic alliance; AG = agreeing goals; GGI = gaining and giving information)

- **Phase seven: Engaging the patient**

  As a result of a discussion with my supervisors it became apparent that there were a number of limitations to my theory:
  - it was rigid and mechanistic;
  - it was dominated by the conditional matrix;
  - I had lost the sense of process so integral to symbolic interactionism;
• the literature was stifling the data;
• I had failed to incorporate the properties and dimensions identified in the earlier analysis.

Whilst this was a considerable blow at the time, it forced me to take a fresh look at my analysis. I went back to the transcripts, re-read them and let the data tell its own story. The phrase “getting the patient on-board” was a recurring one that I had noted in my early analysis. However I had failed to fully appreciate its significance. Whilst this was not a “eureka” moment, it was a turning point in formulating my theory. I recognised that for the participants PCC was not a process of attaining congruence, it was one in which the physiotherapist attempted to engage the patient in the therapist’s goal of self-management. To this end, all the actions and interactions were focused on this process. Through further refinement the names of the sub-categories were modified to reflect a more dynamic process and a new sub-category was introduced. The therapeutic alliance became developing an alliance; agreeing goals and the gaining and giving of information were subsumed into a single sub-category entitled reconciling perspectives as I recognised that this was the ultimate goal of the two processes; interpreting the problem was identified as the aim of the assessment process. The core category was confirmed as engaging the patient, a process I had identified in phase 3. Unfortunately I failed to recognise its significance at that stage (Figure 4.7).

The influence of the intervening conditions was recognised in the final theoretical conceptualisation of the theory. This will be presented in Section 5.6.

Figure 4.7: Engaging the patient
4.11 Summary of the method

This chapter has detailed the operationalisation of the study including the developmental work, ethical issues, data collection and analysis. An overview of the method is provided in Figure 4.8.

![Figure 4.8 Overview of the method](image)

The analysis has been described and a detailed audit trail provided. The analysis eventually culminated in the identification of the core category of *engaging the patient*. The process of identifying the core category was not straightforward. At the time the experience was a source of considerable frustration. However, as a result of prolonged deliberation and discussion, I feel confident that the final model provides a theoretical conceptualisation of PCC that rises above a conceptual description of themes (Charmaz, 2006:102; Cutcliffe, 2005). The next chapter presents the findings of the study and relates them to the relevant literature.
5.1 Introduction

In this chapter the major findings of the study are presented and discussed. The aim is to take the reader on a metaphorical journey of a patient attending for physiotherapy with a diagnosis of low back pain (LBP). The chapter begins with a representation of the findings in the form of a story line. As discussed in relation to the analysis and interpretation of the data (Section 4.7), the story line is the “the conceptualisation of the story.” Following the story line, the results of the process of theoretical integration, the three subcategories and core category, are explored in-depth. The chapter concludes with the results of the theoretical coding where existing theoretical frameworks were applied to explicate the components of the theory and the relationships between them.

The focus of the chapter is on a rich description of the findings, illustrated with quotes from the participants and related to relevant literature. The quotes were selected on the basis of their ability to best illustrate the categories and as such some participants are more represented than others. However, where an individual participant articulated a negating or opposing sentiment to the other participants, this is included.

As discussed in relation to the methodology (Section 3.4.3), the use of the literature in grounded theory (GT) has attracted some controversy. In the study the literature became increasingly important as I wrote the categories. It assisted in their development, clarification and conceptualisation. As a result I was exposed to a whole body of literature with which I was unfamiliar prior to embarking on the study. My perception is that as a result of applying the work of others, my theory has been reinforced and its explanatory power augmented.

5.1.1 The story line

The findings of this study suggest that patient-centred care (PCC) is perceived as a processual journey of engaging the patient in a working alliance (Figure 5.1). This was summed up by participant 1:
The journey consists of three inter-related social interactions which are focussed on the central interaction of **engaging the patient**. The process is highly influenced by the two individuals involved; the patient and physiotherapist. Consequently the process is unique to each therapeutic encounter.

![Figure 5.1: The story line](image)

At the start of the journey there is a situation of potential dissonance between the two individuals, the extent of which may be on a continuum from polarisation to relative agreement. The dissonance is a reflection of the attitudes, beliefs, expectations, knowledge and understanding of the patient and physiotherapist. It is suggested that the belief systems of health care professionals towards their patients influences patient-centredness (Atkins & Ersser, 2008:79). Additionally they are important in the management of chronic LBP (Ostelo, Stomp-van den Berg, Vlaeyen, Wolters, & De Vet, 2003). It is also suggested that the sum of a person’s beliefs forms the basis for their subsequent behaviour (Daykin & Richardson, 2004). The goal of the interactional processes is to attain a more congruent position between the patient and the physiotherapist.
The process begins with the initial assessment of the patient’s problem by the physiotherapist. As a result of the social interaction of interpreting the problem, the physiotherapist interprets the patient’s back problem according to their own socially constructed definitions. Such definitions are influenced by their beliefs, attitudes, expectations, experience, knowledge and extensive professional socialisation. In light of the complexity associated with the multi-faceted and heterogeneous problem of LBP, the assessment information is conceptualised into factors which are modifiable by physiotherapy, and those which are not. The process of reconciling perspectives occurs simultaneously with that of interpreting the problem. In this social interaction, the physiotherapist strives to reconcile the potential incongruence between their own belief system and that of their patients. This occurs primarily, although not exclusively, through the provision of information. Consequently the patient is perceived to have a greater awareness and understanding of their problem and a more realistic view of their role and the role of physiotherapy in its management. Developing an alliance with the patient is perceived to be integral to the process of engaging the patient as without it congruence is not possible.

Engaging the patient is at the heart of the journey. It is driven by the professional philosophy that self-management is the optimal outcome of physiotherapy. Consequently it is perceived that the responsibility of the physiotherapist is to act as a facilitator, whilst the role of the patient is to be involved in their management. The promotion of this goal of management involves a variety of strategies including the identification of management goals and the involvement of patients’ in the decision-making process. The model of professionally driven best interest compromise (Sandman & Munthe, 2010) reflects the professional dominance of this social interaction.

The culmination of successfully engaging the patient is the establishment of a working alliance whereby the patient and physiotherapist work in partnership to help the patient with a particular problem. The characteristics of the alliance are illustrated by the vignette of an “ideal patient”. In this scenario both parties start from a position of congruence in that the patient has a clear and realistic functional goal that is amenable to physiotherapy. The physiotherapist uses their clinical reasoning skills to analyse the problem and develop a plan of management. Whilst
the professional dominance of the process is evident, the two parties clearly work in collaboration and the outcome is successful.

I mean I love it when a patient comes with clear goals. I had someone before that wanted to be able to get on the ground to play with her grandchildren or something and you know we really broke it down into improving moving and then got her in, practicing kneeling, getting on and off the floor, and things like that.

You know I think I definitely get a buzz from doing that and if they do achieve it then you really see that they can and you get that feedback from them. I often think that those are the reasons why I do this job when you have someone like that who really responds to you, does what you recommend, practices what you recommend, you get the buzz from that. (PT6: 13: 623)

Vignette of the “ideal patient”

The analytical techniques of GT involve the application of existing theoretical frameworks to enhance the explanatory power of a theory. It is proposed that complex responsive process of relating (Suchman, 2005) provides a theoretical framework for the interactions of interpreting the problem and reconciling perspectives. This posits that all human action results from the interactions that occur both between individuals and within the human mind. It is evident that developing an alliance with the patient is integral to engaging the patient as without it congruence is not possible. Theoretical constructs from the counselling literature are proposed to provide a framework for this interaction. These include: a real relationship (Gelso & Carter, 1994); facilitative attributes of the therapist (Mearns & Thorne, 1988) and the instrumental use of self (Rowan & Jacobs, 2002). The process of engaging the patient is explained theoretically by the theory of communicative action (Roderick, 1986) (Figure 5.2).

The findings suggest that the process of engaging the patient is not always straightforward or indeed attainable. The extent of the dissonance at the start of the journey can profoundly influence the subsequent stages:

You know I think if they come expecting that they might need to do a bit more exercise then they're more agreeable, but if they think they need something else then they won't be (PT6: 11: 523)
Figure 5.2  Theoretical conceptualisation of patient-centred care

It is possible that this cannot be resolved. This is reflected in the following quotes where there is clearly a situation of dissonance, non-adherence and poor outcome:

*I think there are those patients who think you are talking a load of rubbish and think they know best and go away and then come back and complain “I am not any better”. And you are like “well you haven’t done anything of what I have asked you to do, you are not following it”.*

(PT2: 8: 322)

*Those patients are very difficult to change because they are not accepting things or they just don’t want to do what you say but that is fine. I will say “that’s fine, go back and see your doctor and we will refer you on to see so and so”*

(PT1: 4: 146)

Additionally the process is highly complex and associated with a number of tensions and inconsistencies. A number of factors at a macro level served to
thwart its development. These include the lack of coordination of services for patients with LBP and the predominantly biomedical education of physiotherapists. In contrast it is facilitated by micro factors such as the communication skills of physiotherapists, their experience and the level of departmental support.

This chapter now presents the findings of the study that culminated through an extensive period of analysis, memoing and constant comparative analysis, into my substantive theory of patient-centred care in musculoskeletal physiotherapy from the perspective of the participants.
5.2 Interpreting the problem

5.2.1 Introduction

Interpreting the problem represents the first stage in the process of engaging the patient. This sub-category relates to the problem of low back pain (LBP) and refers to the process whereby the physiotherapist obtains an understanding of the patient’s back pain, particularly through the initial assessment. The sub-category was refined from the early open code of assessing the patient. A considerable number of the initial concepts were related to it; an indication of the importance attributed to it by the participants. It was refined through the concept of gathering information. As the coding became more refined, I recognised that the purpose of questioning the patient, listening to their responses, picking up cues to tailor subsequent questioning was to enable the therapist to unravel the various components of the problem into one that has meaning for them. The sub-category was further developed through axial coding which identified three properties:

- clinical ambiguity: LBP can be managed in more than one way, the level of ambiguity is less with straightforward problems;
- professional uncertainty: the physiotherapeutic management of back pain is unclear, the level of uncertainty depends on the complexity of the problem and other intervening factors;
- reciprocity: a mutual exchange of knowledge, thoughts, feelings and actions between the patient and physiotherapist (Titchen, 2001:74) which can range from a one-way to a two way exchange.

In the sub-category the challenge of back pain represents the condition that leads to the interaction of conceptualising the problem. The key issue that has to be addressed is termed “opening a can of worms”; a phrase adopted by a number of the participants. The interaction is considered to be a process of conceptualisation of the problem, the result of which is an unpicking of the problem. The process of interpreting the problem is influenced by a number of facilitating and constraining factors. The sub-category along with its properties and dimensions is illustrated in Figure 5.3. The findings of the process of axial coding are now discussed and related to interpreting the problem along the lines of its properties and dimensions.
Each section is completed by relating the findings to the relevant literature to conceptualise the data and formulate meaning.

Figure 5.3: The results of axial coding for interpreting the problem

5.2.2 The challenge of low back pain

Interpretation of the patient’s problem by the participants was necessary because of the issue of managing a complex and heterogeneous musculoskeletal problem in the presence of limited specific guidance for physiotherapists. It was evident that the participants had adopted the guidelines developed by the Clinical Standards Advisory Group (1994) and Royal College of General Physicians (Waddell et al., 1998), however the applicability of the guidelines to physiotherapy practice was a source of considerable frustration:

You have got things like you have got your simple back pain; you have got your nerve root problems and your serious pathology and that is it. People just sit in those three categories and it’s like simple pathology go to physio and that is fine but where is the bit when he goes to physio? (PT2: 13: 531).

It was also recognised that the focus on acute problems did not reflect the majority of patients presenting to physiotherapists who presented with more chronic
symptoms. The degree of clarity surrounding the management of acute pain was in stark contrast to that associated with chronic problems:

_Because there is all those things about an acute back with red flags, everyone can spot the red flags, but there is not a lot on chronic_ (PT1:8:336)

During the course of my study guidelines for the early management of persistent LBP were published (National Institute for Health and Clinical Excellence, 2009) (Section 2.6.1). Whilst this was welcomed by the participants, it was also evident that these guidelines did not fully address the clinical ambiguity and provide the level of preciseness and certainty they required:

_So acupuncture for instance is something we love here, and now we’ve got the NICE guidelines to back it up for lower back pain_ (PT9: 2: 60)

_I want something more and specifically for physiotherapy_ (PT2: 14: 583)

The resulting void meant that patients potentially experienced considerable variations in practice depending on the treating physiotherapist. This subjectivity was acknowledged by the participants:

_If you send the same patient to like five different physio’s they will have five different treatments and again they might get better with all five_ (PT2: 13: 552)

_You know you can see one therapist and have a great response, see another and not get anything out of it_ (PT7: 9: 331)

i. **Concept building in relation to the challenge of back pain**

The absence of clear guidance regarding the most appropriate management for patients with LBP provides a considerable challenge to physiotherapists and other health care professionals. Current evidence around different techniques and modalities is unclear and “_does not easily provide the answers that physical therapists need regarding clinical questions, such as which intervention to use with a specific client_” (Mikhail, Korner-Bitensky, Rossignol, & Durmas, 2005). As a result of the clinical ambiguity it is suggested that the treatment provided to a patient may reflect the skill, personal idiosyncrasies or beliefs of the practitioner,
rather than the needs of the patient (Waddell, 2004:2). The participants clearly recognised this issue.

The few studies that have explored physiotherapy practice for LBP acknowledge the variability of physiotherapy practice. A questionnaire survey in 1999 revealed little consensus regarding the optimal management approach (Foster et al., 1999) and a greater focus on pain relief compared to functional ability. Gracey, McDonough and Baxter (2002) reported similar findings and also indicated that patients with LBP were treated with a wide range of modalities, frequently in combination. Mikhail et al., (2005) found that although the majority of physical therapists in their study utilised more evidence-based active interventions, they still reported the use of 43 different interventions for a patient vignette. More recently it was shown that although there was consensus between expert clinicians in relation to many aspects of physiotherapy for patients with LBP, uncertainties remained in a number of areas of practice (Ferguson, Brownlee, & Webster, 2008). Whilst these studies provide an insight into the interventions utilised in physiotherapy practice, they did not explore the reasoning processes undertaken by the physiotherapists to justify the interventions.

The nature of back pain accompanied by the lack of clear guidelines for its management means that physiotherapists are operating in an environment of clinical uncertainty. Mullavey-O’Byrne and West (2001:55) suggest that a desire for certainty is “a silent partner” in a therapeutic encounter. Together they create a “state of expectancy” whereby the patient expects the health practitioner to provide the answer to their problem and the practitioner wishes to provide the answer (Mullavey-Byrne & West, 2001:56). In the face of this uncertainty it is evident that the participants utilised a discipline specific method of assessment and reasoning to inform their management decisions and these are now discussed.

5.2.3 Conceptualising the problem of low back pain

Conceptualising the problem of LBP into one that was meaningful to the participants incorporated a number of strategies. These are outlined in Figure 5.4 and are now explored.
i. **Assessment**

An exploration of physical and psychosocial factors occurred predominantly, but not exclusively, in the initial encounter with the patient. It was evident that the participants viewed the initial assessment as the first step to attaining congruency and engaging the patient. It was considered as vital for building an alliance with the patient:

*Big thing is trust, the initial contact. If you don’t get their trust straight away that is it* (PT9: 3: 108)

To this end the importance of the subjective component was highlighted:

*So all of the clinical reasoning process probably starts right then and if you haven’t actually completed that then I don’t know whether you’ve got that full understanding of the condition*  (PT6: 10: 448)

The participants did not overtly discuss the type of assessment they undertook with the patients. This may be because they assumed that I was aware of the format, or because it was a habituated part of their professional role that did not require articulation. It was evident from their responses that it broadly incorporated
a biomedical, social and psychological perspective. Table 5.1 illustrates typical quotes from the participants.

<table>
<thead>
<tr>
<th>Assessment approach</th>
<th>Illustrative quotes</th>
</tr>
</thead>
</table>
| Biomedical          | • After taking the history, if it is chronic or if it is acute, you look at it very differently; clinically reason very differently (PT3: 1: 20)  
                       • So probably looking at it from a mechanical point of view as well, what positions they’re in that are aggravating and easing (PT6: 2: 24) |
| Social              | • I think if you can get a better understanding about the social side then it allows me a bit more scope to formulate goals with them (PT6: 2: 71) |
| Psychological       | • Trying to get them to explain what their views are and what they know (PT2: 2: 82)  
                       • When you are getting their history, very often you will pick up from them what their problem is or what they perceive their problem to be (PT3: 3: 101)  
                       • You’re thinking very physiologically, mechanically what structures could be affected here and you’re also picking up all of their expectations and understandings around it as well (PT6: 10: 446) |

Table 5.1: The assessment approach of the participants

In order to obtain a clear understanding of the patient’s problems, the participants undertook a detailed subjective assessment including the history, the presence of “red flags” and the behaviour of symptoms. An exploration of the patient’s social circumstances was considered important to facilitate their engagement with the management programme. It was apparent that the assessment of biomedical factors and social influences was relatively straightforward. This probably reflects the routine nature of this approach and the confidence the participants feel in executing this traditional form of assessment. In contrast, the assessment of psychological factors was more inconsistent and challenging for the participants. Information relating to psychological factors was elicited either through overt questioning or more subtly through attending to their responses to other questioning. The assessment of psychological factors clearly presented an issue to the participants and this is revisited later in this section. Finally, it was evident that in the initial assessment, reciprocity was more a one-way rather than two way exchange of information. It was primarily an information gathering exercise led by
the physiotherapist. The extent to which it incorporated the patient’s knowledge, thoughts and feelings is questionable.

The participants adopted a number of strategies to assist their exploration of the patient’s problem. They took time to ensure that the patients were aware of the structure and content of the initial assessment:

There is so much information I need to get from you and there is so much that I need to actually do as well. I may have to do some certain tests, some movements, maybe feel some areas. So I think at the outset I tell them my plan for that half an hour and then I try to follow it through. (PT3: 5: 197)

If required, they were able to adapt the timing and format of the initial assessment:

Sometimes it won’t be possible to get everything done and I will say we will complete a few more tests next time and then discuss our treatment (PT6: 3: 134)

The importance of well developed communication skills was frequently referred to by the participants. Listening to the patient was integral to the assessment process. This often meant listening to information regarding the process of their care rather than information directly related to their problem:

You have to listen to everything they have been through and that they’re not happy and you just try and appease it as much as possible and go “yes I understand” and those sort of things. Very much a shoulder at times (PT7: 11: 417)

Attending to verbal and non-verbal cues was also evident. The language adopted by patients gave the participants an indication of their understanding and motivation:

“They told me my knees were crumbling” or “the discs you know shot to pieces” then I will pick up obviously their understanding of the situation from the type of words that they used (PT6: 4: 162)

I think from body language you can probably tell a little bit and how much information they are volunteering as well. I think some patients you have to kind of drag the information out of them a little bit and they almost look a little bit disinterested (PT5: 9: 377)
ii. **Categorisation**

After gathering information from the patient in the initial assessment, it was evident that the participants adopted a form of categorisation of the back problem. Two main approaches were evident (Table 5.2). The first was a broad division according to chronicity, alongside a recognition that this may be over simplistic. The second was a relatively new mechanism of sub-classification (O'Sullivan, 2005).

<table>
<thead>
<tr>
<th>Categorisation</th>
<th>Illustrative quotes</th>
</tr>
</thead>
</table>
| **Chronicity** | • So if it’s an acute phase then obviously I’m going to treat it differently to a chronic phase and then it can be an acute on chronic exacerbation then again it can be slightly different (PT9: 2:55)  
• You get some that have acute problems on top of chronic as well and then sort of different medical problems and conditions alongside their back pain as well which will have an impact (PT5: 2:50) |
| **Sub-grouping** | • So I do use a sort of categorisation in my mind, this is a chronic back, so whether they are more motor control, weakness, whether they are more stiff down the spine or whether they have got more loading issues (PT1: 2:50)  
• So I will fit them into a category there and then direct my treatment to what is best for them (PT9: 9:446) |

**Table 5.2:** Categorisation of back problems adopted by the participants

Participant two was optimistic that the research into sub-classification would assist in the effectiveness of treatment:

*Hopefully sub-categories are coming along and hopefully they will start to identify the different sub-groups and stuff and then we can find the appropriate treatment* (PT2: 14:561)

iii. **Integration**

There was consensus amongst the participants that “self-management” by the patient was the ultimate goal and that their role was to act as a facilitator by providing the patient with strategies through which they could manage their problem (Table 5.3).
**Emphasis on patient self-management**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not here to make them better I am here to help them get themselves better</td>
<td>(PT4: 6: 259)</td>
</tr>
<tr>
<td>I like to give the patient the tools, they’re seeing me for half an hour, but what they’re doing 24/7 is really going to make a difference</td>
<td>(PT9: 2: 83)</td>
</tr>
<tr>
<td>Try and put the focus on them to kind of manage the back themselves rather than relying on sort of specific physio techniques</td>
<td>(PT5: 1: 23)</td>
</tr>
</tbody>
</table>

**Table 5.3: Self-management as the goal of physiotherapy**

The process for integrating the information from the patient with the participant’s philosophy of care and goal of management appeared to be a largely tacit and intuitive process. It was most succinctly summed up by participant nine:

> So all those considerations, the physical and psychological need to come into play with your management approach  

> And then you take yourself, your own experience with patients, what you find works and you stick it all in big salad, stick it together and you come out with what works, but again it can be different with each patient  

| (PT9: 2: 58)                                                                 | (PT9: 2: 100)   |

**iv. Concept building in relation to conceptualising the problem of low back pain**

The interaction that dominates this sub-category is the initial assessment of the patient by the physiotherapist (Section 2.7). The assessment could be considered to be a “routine interaction” between the physiotherapist and patient in which the physiotherapist generally follows a structured format. The term “interactional expertise” has been adopted to describe the application of a health professionals’ specific knowledge (e.g. history taking, diagnostic reasoning and the provision of explanations) to the clinical encounter (Sarangi, 2005:103). It has been suggested that through this interaction the meaning of LBP for the patient is interpreted by the physiotherapist and may be renegotiated (Parry, 2004a:71). A biomedical approach was evident for all the participants. In addition it was also evident that the participants had embraced recommendations to integrate an assessment of psychosocial factors into their assessment (Waddell, 2004:278; Watson, 1999), however their approach to assessing these issues varied considerably.
The past decade has seen the emergence of a body of evidence highlighting the importance of psychosocial factors in the development of chronic LBP (Van der Windt et al., 2008) (Section 2.6.2). Although the term psychosocial was not adopted in the PCCM, it was suggested that doctors should explore the patient's illness experience in conjunction with their conventional medical examination (Belle Brown, Wayne Weston, & Stewart, 2003b). In their conceptual framework, Mead and Bower (2000) suggested that a biopsychosocial perspective was necessary for doctors to appreciate the full range of problems presented by their patients. They extended this to incorporate the personal meaning of the illness for the patient, the consideration of the patient as an “experiencing individual” (Mead & Bower, 2000:1089). From the patient’s perspective, Cooper et al., (2008) did not delineate this as a separate dimension in their model, perhaps highlighting a difference in perspective between the perceptions of the therapist and patient. However, the patients did want the physiotherapist to get to know them, reflecting a broader perspective than the biomedical model.

It was evident that in the initial assessment the participants utilised both diagnostic and narrative reasoning processes (Edwards et al., 2004a) (Section 2.7). It was also clear that diagnostic reasoning dominated the process. Whilst the process of diagnostic reasoning did not appear to be associated with any particular issues for the participants, it has been found that physiotherapist’s perceptions of their patients level of pain and functional limitation is only moderate (Perreault & Dionne, 2005). This perhaps challenges current methods of assessing these variables, as discrepancies may result in inappropriate treatment decisions.

The categorisation of back pain has attracted some attention in the literature (Section 2.6.3). In contrast to the findings of other studies (Foster et al., 1999; Kent & Keating, 2005), the participants did not apply pathoanatomic labels to LBP, relying instead either on a broad division according to chronicity, or a relatively new mechanism of classification proposed by O’Sullivan (2005). Despite the limited evidence for this approach, some of the participants found it useful for providing added confidence to manage patients with chronic pain.

The integration of information from the patient with personal perspectives and experience appears to be related to the processes of cognition and metacognition
associated with contemporary models of clinical reasoning (e.g. Higgs & Jones, 2000) (Figure 5.5). Cognition refers to the synthesis and analysis of new information whilst metacognition relates to self-awareness and reflection (Jones et al., 2008). It is however recognised that the applicability of such models to actual physiotherapy practice requires further study (Jones et al., 2008) and hence it is not possible to provide a definitive theoretical underpinning for this process.

![Clinical reasoning](image)

**Figure 5.5:** Clinical reasoning (Higgs & Jones, 2000)

### 5.2.4 Opening a can of worms

In contrast to the apparent ease of questioning in relation to biomedical and social factors, the assessment of psychological factors was more problematic. The participants appeared reticent and uncomfortable:

*If you start delving into someone’s personal life, you have to be very careful with what you say and what you ask*” (PT1: 9: 368).

*It is very very difficult and it is not something that you learn overnight* (PT3: 6: 240)

The analogy of a “can of worms” was a common expression:

*If you don’t have the experience to deal with it you are going to open a can of worms with some people. So I guess sometimes it is easier not to even go there* (PT1:11: 463)
The issue of compensation and the influence it may have on a patient’s progress was a particular challenge for some of the participants as they did not want the patient to feel that they doubted their symptoms:

> And again it is quite difficult, as soon as you mention that word (a claim), are they then thinking “he thinks I am making it all up and lying”

(PT5: 7: 278)

Some participants balanced the challenges with their professional role:

> If it is relevant to the reason they are being referred to the department and it’s part of how you would manage that problem, then I think it has to be dealt with

(PT5: 8: 319)

Questioning in relation to beliefs was not evident and specific questioning related to expectations was variable and inconsistent. Some participants appeared to address expectations only if they were encountering some resistance from patients. Table 5.4 illustrates some typical quotes from the participants.

<table>
<thead>
<tr>
<th>Expectations</th>
</tr>
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<tbody>
<tr>
<td>Initially you have to kind of establish what they understand by physiotherapy and what their expectations are when they first come. (PT5: 2: 65)</td>
</tr>
<tr>
<td>I have to say probably sometimes I don’t always directly ask. So I suppose the rest of it would be picked up in general conversation maybe throughout when we’re just doing the objective or subjective. (PT6: 4: 153)</td>
</tr>
<tr>
<td>If I find that they are not being realistic, I will ask them “what do you want out of physiotherapy? or what would you like to be able to do?” and I will ask them that quite bluntly. (PT1: 12: 510):</td>
</tr>
</tbody>
</table>

Table 5.4: Illustrative quotes relating to expectations

Perhaps reflecting its relative importance to biomedical questioning, participant nine indicated that there may not be sufficient time in the initial assessment to address expectations:

> If you get time in the initial contact, “what sort of things do you want to get out of physio? You know what are your main problems?”

(PT9: 5: 201)

The participants adopted a number of strategies to meet the challenge of questioning the patient regarding psychological factors. Overt questioning was not evident and it appeared to be left to the patient to volunteer information. Participant nine was comfortable asking questions if the patient initiated the conversation:
And then they say “I’m on antidepressants” and then you know “how long have you been on those?” I won’t go any further and say “is there a reason, a traumatic event or anything?” (PT9: 7: 340)

However as illustrated by participant seven, there appeared to be a reluctance to pursue the responses:

I try not to press too much if I’m not comfortable with it, or they’re not comfortable I’ll leave it, but if they’re ok with it I will press on (PT7: 13: 476)

Questioning was facilitated by attending to the wording of questions. The use of open questions, sensitivity to the patient and their relationship with the patient were identified as factors that facilitated their ability to explore psychological factors:

I think you have got to do it in a very tactful way and it depends on the patient’s personality (PT1: 9: 372)

It might be something I ask maybe later on when I feel I’ve built up a bit more of a rapport (PT6: 16: 751)

i. Concept building in relation to opening a can of worms

There appears to be a consensus for a biopsychosocial approach for the management of LBP within physiotherapy (Ferguson et al., 2008). It is also evident however that there is some tension in the literature surrounding the implementation of a biopsychosocial approach. Whilst physiotherapists are urged to give psychosocial information the same significance as information relating to the patient’s symptoms, concern has been expressed that a number of factors may militate against such an approach (Goldingay, 2006b). These include the structured format of the assessment process and its attendant focus on sources of symptoms and tissue dysfunction. Whilst the participants indicated that there was flexibility in their assessment, it was also evident that they had a professional remit to meet. Support for this focus comes from Daykin and Richardson (2004) who found that the physiotherapists in their study held a predominantly biomedical perspective of chronic LBP. Goldinghay (2006a) has suggested that the development of a biopsychosocial perspective goes “hand-in-hand” with effective
communication skills and proposed a number of strategies by which these can be attained. However it was acknowledged that contextual factors will influence the extent to which this can be achieved in practice.

### 5.2.5 Facilitatory and constraining factors

Two factors related specifically to *interpreting the problem*:

- training in the assessment of psychological factors;
- chronicity of the patient’s problem.

In terms of *psychological factors*, the participants had not received specific training at undergraduate level:

> My undergrad training was years ago and the psychological and the chronic back pain really wasn’t mentioned  

(PT2:7: 296)

There were however mixed feelings as to the advantage of such training. Whilst some participants were doubtful it would beneficial, the participants who had undertaken some additional training found it helpful. Participant four had worked in psychiatry and participant two had completed a pain physiology module which covered the management of chronic pain:

> I don’t think you get the right training, but I don’t know what the right training would be to be honest. You can do scenarios, but until you are faced with the patient  

(PT3:7: 271)

> Having done some psychiatric sort of postgrad training some years ago, it did help me a lot. Sort of not necessarily run away from any issues that the patient might have  

(PT4: 4: 161)

Interestingly participant six indicated that whilst courses in this area are available, they are not as appealing as more practical skill based courses:

> Those courses don’t appeal because they’re more like thinking, philosophy kind of you know courses I suppose and thoughts and it doesn’t feel as exciting that you’re learning new things  

(PT6:16: 732)

In the absence of training, experience was identified as a key factor in enhancing the participant’s ability to deal with complex issues and it was recognised that this was a particular issue for junior therapists:

> I think as I have got more experienced I feel more comfortable doing it  

(PT6: 16: 742)
I think it really terrifies them especially if they have multiple problems and it is focusing on what is important for the patient as well as everything else that they have told you, and it is very difficult to unpick and it is daunting (PT1:9: 363)

The pressure on the physiotherapists to identify the patient’s problem quickly was recognised and this was viewed as an additional burden for junior staff:

If you haven’t worked out what the problem is after the initial assessment, you’re going to have problems further down the line (PT9: 10: 496)

The chronicity of the patient’s problem was both a facilitatory and constraining factor. In the presence of more acute symptoms the participants were clear as to the management. It was evident that acute LBP did not present them with particular issues and they viewed the problem as one that could be resolved:

I think generally there are the acute ones that hopefully you can return back to a normal function (PT2: 1: 33)

There was no professional uncertainty and participants broadly offered symptomatic relief along with a return to normal movement:

If it is an acute thing that can be fixed, I probably would go into treatment fairly quickly and sort of using different techniques (PT5: 1: 18)

In contrast, the management of chronic symptoms was more challenging and was associated with ambiguity and uncertainty:

I think it is so complicated that the more you go into it – it gets more complicated. But it is not just a local thing it is widely known that it is very difficult to treat and manage back pain (PT1: 8: 338)

I have got to talk to them, there is no instant fix, it is a bit more hard work, it’s more of a mental drain on yourself as well. It’s a harder patient group to deal with. (PT2: 11: 455)

i. **Concept building in relation to facilitatory and constraining factors**

It is suggested that the current education system within physiotherapy, both at undergraduate and postgraduate level, has failed to fully embrace the biopsychosocial model. This is reflected in the difficulty many therapists experience with integrating this approach into their practice and potentially facilitating their management of more chronic problems (Bishop & Foster, 2005).
Daykin and Richardson (2004) have been highly critical of repeated calls for a psychosocial approach without the appropriate training programmes in place, starting at undergraduate level. It is interesting to note that training at postgraduate level did not appear to be appealing to the participants. Studies that have provided additional training have reported mixed results. Two trials demonstrated that the provision of additional training in cognitive behavioural therapy (CBT) interventions to physiotherapists resulted in small additional benefits for LBP and disability (Johnson, Jones, Wiles, Chaddock, Potter, Roberts, Symmons, Watson, Torgerson, & Macfarlane, 2007; UK BEAM 2004). In contrast Lamb et al., (2010) reported long term clinical and cost effectiveness of the approach; however in this study the CBT intervention was delivered by a number of health professionals including psychologists. Whilst it is suggested that brief training in CBT may be insufficient to bring about significant changes in the selected outcome measures (Johnson et al., 2007), the training provided to the health professionals in all three studies was comparable. It may be that physiotherapists as a professional group feel reticent in delivering CBT. Green, Jackson and Klaber-Moffett (2008) demonstrated that despite participation in a training programme based on CBT, the physiotherapists in their study were hesitant and under-confident in implementing such an approach.

5.2.6 Unpicking the problem
Faced with the complexity of many patients’ problems, the participants re-interpreted the information into factors that were amenable to physiotherapy intervention and those that were not:

*Try and pick where the main problem is and where your physio role is and what you can actually change and so yeah you just try and unpick it into physio things that you can change* (PT8: 6: 186)

As a result of the interpretation of the patients’ problems, the participants were able to proceed with their management. To this end the formulation of goals was frequently discussed. The process of goal setting was not always straightforward and this will be discussed further in relation to the core category.
i. **Concept building in relation to unpicking the problem**

Blumer (1969:69) has suggested that back pain can be viewed as an object and physiotherapists act towards it according to the meaning it has for them. Such meaning is constructed through a process of social interaction. For musculoskeletal physiotherapists this construction is shaped by numerous influences including their professional role with its own discipline specific beliefs and practices, their experience and personal preferences. Human action consists of interpreting what is presented and constructing a line of action on the basis of this interpretation. In terms of managing LBP, the physiotherapists interpret the information obtained in the assessment according to their socially constructed definitions to formulate a management plan for the individual patient.
5.3 Reconciling perspectives

5.3.1 Introduction

Once the physiotherapist has interpreted the patient’s problem into one that has meaning for them, the next stage in the process is to reconcile this perspective with that of the patients. The key strategy by which this occurs is through the provision of information. This does not occur in a linear format following the initial assessment but often within the same interaction:

"You might even start some of the explanation and stuff about the problem at that stage before you’ve even finished the subjective" (PT6: 10: 459)

The sub-category was refined from the early open codes of: managing expectations; informing the patient and patient’s expectations. Initially it was labelled as a category of communication with the patient and subsequently as gaining and giving information. The sub-category was further developed through axial coding which identified three properties:

- mutuality of outcome: the extent to which the goals of therapy are shared by the patient and physiotherapist, this can range from common to divergent;
- expectations: the patient’s anticipation of the process and outcome of physiotherapy, this may range from realistic to unrealistic;
- attitudes: the patient’s view of physiotherapy which may range from congruent to incongruent with that of the physiotherapist.

In the sub-category the incongruity between the beliefs and goals of the patient and physiotherapist represents the condition that leads to the interaction of conveying information. The key issue determining the success of the interaction is the communication skills of the physiotherapist in managing the incongruence. As a result of the interaction, it is considered that the patient has a greater understanding of their back problem, the respective roles of the patient and physiotherapist in managing it and more realistic expectations of the outcome. The process of reconciling perspectives is influenced by a number of facilitating and constraining factors. The sub-category, along with its properties and dimensions, is illustrated in Figure 5.6. The findings of the process of axial coding are now discussed and related to reconciling perspectives along the lines of its properties.
and dimensions. Each section is completed by relating the findings to the relevant literature to conceptualise the data and formulate meaning.

**Figure 5.6:** The results of axial coding for *reconciling perspectives*

### 5.3.2 Incongruity of beliefs and goals

The participants perceived that frequently there was a lack of congruity between their own expectations and attitudes and those of the patients, in relation to the management of LBP. Both concepts relate to beliefs. A belief is an acceptance by the mind that something is true or real (Encarta Dictionary). Attitudes are based on beliefs resulting from life experiences; a person’s attitude refers to the most significant beliefs at a particular time (Barron, Klaber Moffett, & Potter, 2007). Expectation is also a belief and relates to the anticipation of something happening (Thompson & Suñol, 1995). Patient expectations and the management of them were two of the commonest early open codes. The participants perceived that patient expectations were shaped by a number of factors. The most prevalent influences are outlined in Figure 5.7 and illustrated by quotes in Table 5.5. As evidenced by the number of quotes related to this topic, it was clearly perceived to be a significant factor in terms of engaging patients. It is interesting to relate this to
the lack of overt questioning regarding expectations highlighted in interpreting the problem.

**Figure 5.7: Influences on expectations**

The participants perceived that a patient’s level of knowledge and understanding of their problem was key in shaping unrealistic expectations. At times the knowledge deficit was perceived to be at quite a basic level. Interestingly participant seven indicated that patients who have undertaken extensive research into their problem may come with inappropriate ideas about their condition and how it should be managed:

*They say knowledge is power, but sometimes it’s dangerous*  
*(PT7: 6: 236)*

Perhaps unsurprisingly previous experience of physiotherapy was identified as a factor that influenced the patient’s expectations and perspectives of physiotherapy. It was evident that the expectations of new patients were influenced by their lack of knowledge and experience:

*So I think sometimes they might think they are coming for lots of physio, whereas in fact you might have in your mind that I just need to give them some advice*  
*(PT5: 9: 368)*

*They might just think you are doing a quick assessment and…..you recognise a few problems that need addressing and want to treat them a little bit more*  
*(PT5: 9: 370)*
<table>
<thead>
<tr>
<th>Influencing factor</th>
<th>Illustrative quotes</th>
</tr>
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</table>
| Knowledge and understanding of LBP                    | • I think it is a lot about patient’s understanding about their back pain. Some people come in with a very unrealistic expectation (PT1: 3: 120)  
• We do get some that don’t really understand arthritis…not just with age, but age related degenerative changes and they find it difficult I think sometimes to accept that process is going on and there is not necessarily a cure for it (PT5: 3: 119)  
• Some patients will be spending all day lifting and then they say ‘I have got a bad back’, so it is making them aware (PT1: 6: 248) |
| Previous experience of physiotherapy                  | • Past experiences, if they’ve had a good response to physio or if they’ve had bad experiences (PT7: 6: 202)  
• I mean they might say “well I have had physio before and it hasn’t worked so why am I here again?” (PT5: 10: 413)  
• So it is those ones with experience will probably pipe up and speak a lot more, whereas those who haven’t had any previous experience probably will not say anything (PT1: 5: 207) |
| External influences                                    | • Sometimes they want a treatment because somebody has had it done and they think it is going to work for them (PT1: 3: 104)  
• I think with the internet, the press and the newspapers, there are a lot of things that are written and anecdotal information the patients get and they think that is how things should be and in reality sometimes that is not the case, these are exceptional things that are shown (PT2: 3: 92) |
| Involvement with other HCP                            | • Sometimes I think consultants don’t sit down and talk to patients. Some of them do and do it very well, but some of them don’t and I wonder if sometimes patients then get wrong ideas or wrong expectations from that. (PT1: 3: 128)  
• They (GP’s) won’t have time to fully explain it. They will probably say its age or it’s wear and tear but what does that mean in terms of the anatomy of your back and how it produces pain elsewhere, down the leg and things like that? (PT5: 4: 134)  
• Consultants or you know the specialists they say “go and see”. “Oh go and have this, it will make you better” type of thing without fully explaining (PT7: 6: 234) |
| Involvement with other manual therapists               | • Quite a lot of people will have seeked like private osteopathy or chiropractic and they talk in a very different terminology to us (PT6: 5: 218)  
• Sometime there are patients who have said “my friend saw an osteopath and he was manipulated and he was brilliant and I just want someone to manipulate me and make me brilliant” (PT2: 2: 83) |

Table 5.5   Illustrative quotes relating to factors influencing expectations
External influences such as friends, family, colleagues, the media and the internet were identified as being influential in shaping expectations. The participants recognised that these influences were not always helpful, potentially contributing to the development of unrealistic expectations which then had to be managed. Involvement with other health professionals and manual therapists such as osteopaths or chiropractors were also recognised as significant factors. In general the participants were critical of the information provided by the medical profession. It was also suggested that some doctors propagated the biomedical model by indicating that the physiotherapist could alleviate the problem. The high expectations engendered by such comments were challenging for the participants, as they recognised that patients hold doctors in high esteem:

*What they’ve been told by doctors they think they hold a lot of weight*  
(PT6: 5: 216)

The participants indicated that the patient’s attitude towards them as a physiotherapist was frequently incongruent with their view of themselves as facilitating self-management (Section 5.2.3.iii). They acknowledged that most patients hold their physiotherapist in high regard and value their professional judgement:

*I think a lot of patients would say I want you to treat me with whatever you feel is best – so I think that patients do have respect and they have a lot of trust in their therapists*  
(PT1: 5: 174)

As a result of this attitude some patients expected to adopt a passive role in the management of their problem:

*Patients come in with the notion “right I want you to do what will make me better dear” and they put the onus on you*  
(PT1: 13: 553)

In contrast, a minority wanted to take the lead and some only wanted minimal intervention:

*There are certain patients that will think they can actually dictate what they want*  
(PT4: 6: 220)

*You get patients who are very motivated and you know will go away and do what they have been told to do and don’t necessarily want to come to physio because it’s a hassle*  
(PT3: 9: 353)
In terms of how such expectations and attitudes related to physiotherapy, this was variable (Table 5.6). The participants perceived that unless they had prior experience of physiotherapy, the majority of patients did not know what to expect from physiotherapy; however expectations of a cure were commonplace particularly in patients with chronic pain. In contrast others predicted a more negative outcome. It is evident that the participants perceived that the goals of their patients had little in common with their own goals of self-management.

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Illustrative quotes</th>
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| Curative     | • “I want to be pain free”, you get that a lot and that is where it becomes, you know difficult (PT6: 3: 117)  
• I think we see that a lot especially with some of the more chronic patients …they have had a history of back pain for sort of twenty years plus and they sometimes come in with the expectation that you are going to suddenly fix them (PT5: 3: 92) |
| Negative     | • So some come with their mind set that it's not going to work or you know I’m just trying this before I go to the next option (PT7:11: 414)  
• Some patients think I am never going to get better (PT1: 3: 121) |
| Pre-determined | • So quite a lot of them will have made up their mind what they want before (PT6:12: 544) |
| No expectation | • I think unless they have had a bad experience or they have had a lot of experience with physio, a lot of patients will not really know what to expect from physio (PT1: 5: 176) |

Table 5.6: Illustrative quotes relating to the influence of expectations on physiotherapy

i. **Concept building in relation to incongruity of beliefs and goals**

The participants clearly considered that the patient’s belief system was a significant contributing factor to the potential dissonance between the patient and themselves. Expectations and attitudes were a particular focus with the former attracting considerable attention. They identified a number of factors influencing the expectations and how these could impact on the patient’s perceptions of physiotherapy. The findings reflect the proposed classification by Thompson and Suñol (1995) (Table 5.7) who suggested that a number of personal and social factors serve to develop and modify expectations. The former included needs, values,
experience, information, intentions, interest and moods/emotions, whilst the latter encompassed such factors as socio-demographic characteristics, social norms and group pressures.

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Ideal</td>
<td>The preferred outcome - the patient’s perspective of the potential for physiotherapy</td>
</tr>
<tr>
<td>Predicted</td>
<td>The realistic outcome – what the patient actually believes will happen as a result of physiotherapy</td>
</tr>
<tr>
<td>Normative</td>
<td>The evaluation of what should or ought to happen</td>
</tr>
<tr>
<td>Unformed</td>
<td>The inability or unwillingness of the patient to articulate their expectations</td>
</tr>
</tbody>
</table>

**Table 5.7: Types of expectations (Thompson & Suñol, 1995:130)**

The influencing factors identified by the participants also reflect some of the literature in this area. The lack of knowledge and understanding of LBP could be considered to leave patients vulnerable to misleading information, anecdotal comments and misconstrued advice from a variety of sources. This undoubtedly reflects the lack of specific guidance regarding interventions for LBP, a lack of lay knowledge about the latest concepts for its management and the historical biomedical medical management which predominantly focused on fixing the problem (Section 2.6.1). Klaber Moffett, Newbronner, Waddell, Croucher and Spear (2000) found that there were a number of misconceptions regarding the management of LBP amongst individuals with and without a back problem.

The influence of other professionals involved in managing LBP is also recognised. Klaber Moffett et al., (2000) found that participants in their study who had consulted their General Practitioner (GP), appeared to have more misconceptions compared to those who had not. The lack of certainty surrounding a clinical diagnosis has been identified as particularly problematic for GPs managing chronic LBP (MacNeela et al., 2010). Whilst recent guidelines for the management of back pain do not differentiate between the manual therapy carried out by chiropractors, osteopaths and physiotherapists, the philosophy underpinning the practice of the three professions is
quite distinct (Waddell, 2004:59). Consequently patients are faced with an “*endless jungle of therapies*” (Robson & Gifford, 2006:3) which may contribute to their conceptualisation of their problem and propagate unrealistic expectations of a cure.

Studies that have looked at expectations have revealed some mixed results. Hills and Kitchen (2007b) found that patients with chronic pain either had unrealistically high expectations, or were doubtful as to whether they would obtain any improvement. Cedraschi et al., (1996) also found considerable variation in expectations regarding prognosis. This ranged from complete resolution to worsening, with a number of patients uncertain as to how their problem would develop. In slight contrast, May (2007), found that the majority of patients interviewed in his study of attitudes towards back pain and its management, accepted their problem and were not searching for a cure. Although the author recognised that the study participants demonstrated more chronicity than a “typical” patient with back pain, a temporal element was supported by Liddle, Baxter and Gracey (2007). In their study participants who had experienced a variety of treatments recognised that a cure was unrealistic. Consequently their expectations became more focussed on working with the health care professional to attain better personal control over their symptoms. The greater emphasis on perceived unrealistic expectations in my study is likely to reflect the issues the participants experienced in attaining congruence, rather than the full range of patient expectations they encountered.

The potential relationship of expectations with patient satisfaction and outcomes has attracted some interest. Thompson and Suñol (1995) suggested that expectations are believed to be one of the major determinants of satisfaction. The literature into this however presents a more complex picture. Linder-Pelz (1982) found that it accounted for only 8% of the variance in satisfaction. Hills and Kitchen (2007a) indicated that although it was a significant predictor, this was still less than other factors such as organisation, the therapist, the outcome and communication. In contrast to the results from these quantitative studies, focus group narratives suggest that expectations can influence satisfaction and, importantly, the number of subsequent healthcare consultations (Liddle et al., 2007). It appears therefore that satisfaction is a
multidimensional construct to which expectations contribute to a variable extent depending perhaps on the method of data collection.

In terms of outcomes the literature is also inconsistent. Whilst some studies found no evidence of a relationship between expectations and outcomes (Foster, Thomas, Hill, & Hay, 2010; Klaber Moffett, Torgerson, Bell-Syer, Jackson, Llewlyn-Phillips, Farrin, & Barber, 1999), a systematic review and meta-analysis (Preference Collaborative Review Group, 2008) concluded that preferences are associated with treatment effects. This was however in relation to patient participation in randomised trials and so the clinical application of this finding may be limited. More recently an evidence-based review concluded that although evidence is limited, the beliefs, expectations and preferences of a patient are “likely to influence their engagement and adherence” to their management (Main, Foster, & Buchbinder, 2010:210).

5.3.3 Conveying information

It was clearly evident from the participants that they perceived that many patients presented with unrealistic expectations, attitudes towards physiotherapy that were incongruous with their own and hence divergent goals. As a result the participants were faced with attempting to influence the patient’s whole belief system in relation to their back problem:

\[I \text{ think with back pain a lot of the time it is trying to change their whole concept of what is causing it and how to deal with it} \quad \text{(PT5: 11: 454)}\]

To this end the management of unrealistic or inaccurate expectations was a common goal:

\[\text{It’s trying to manage that expectation of what you can achieve with physio.} \quad \text{(PT7:4:142)}\]

The process by which they addressed these factors was through the provision of information:

\[\text{So I think lots of education I think in terms of bringing their expectations down to a realistic level} \quad \text{(PT5: 3: 106)}\]
It was evident that all the participants considered the provision of information as integral to their role and perceived that they do this to a greater extent than other professions:

*I often feel my role is to bring everything together and make sure that they understand it because I don’t think that always happened*  
(PT6: 7: 302)

The provision of information fell into three main categories:

- an explanation regarding the patient’s problem;
- the patient’s role in the management of their problem;
- the role of physiotherapy in alleviating the symptoms and managing the problem.

As illustrated in Table 5.8, this strategy attracted a considerable amount of attention.

Increasing the patient’s knowledge and understanding of back pain and pain mechanisms was considered important. The focus of this aspect of information provision was biomedical in orientation, combined with reassurances that pain should not act as a barrier to recovery. Consistent with their goal of self-management for patients with LBP, the participants prescribed exercises, provided postural advice and encouraged the patient to take responsibility for their problem. In addition they provided the patients with information relating to the ongoing self-management of their problem.

A topic that recurred frequently was the provision of information regarding the role of physiotherapy in the management of the patient’s LBP. This included procedural information regarding assessment and treatment and a comprehensive explanation so that the patient was completely informed of what physiotherapy involved. It was evident that this was key to the initial assessment and was considered to influence subsequent management:

*So it’s a lot of again education and honesty communication at the beginning and I think if you can get that at the beginning there’s not going to be any false beliefs and hopes further down the line*  
(PT9: 5: 222)
<table>
<thead>
<tr>
<th>Information category</th>
<th>Focus</th>
<th>Illustrative quotes</th>
</tr>
</thead>
</table>
| **The problem**      | • Biomedical explanation  
                      • Pain mechanisms | • I generally leave the cubicle to get the model of the spine and then I'll come back in and I'll explain my findings and try and link them with whatever investigations they've had and then say these are the kind of treatments I think I can offer (PT6: 3: 136)  
                      • And actually a bit about pain itself that you know you might be getting pain, but it doesn't necessarily mean that something's wrong (PT7: 4: 156)  
                      • The pain is there but it is not necessarily causing any harm or doing any damage and I think that is where you need to try and get them to understand that kind of things a little bit more (PT5: 6: 247) |
| **Patients role**    | • Individualised exercise prescription and advice  
                      • Self management | • So I probably spend quite a lot of time explaining maybe like an exercise, for example, what is moving, how it's then going to help, where the restriction is perhaps. (PT5: 4: 172)  
                      • I try and get them doing it in their day to day activities all the things they struggle with like standing at the sink (PT7: 2: 38)  
                      • Explaining how, maybe exercise can help and then giving them maybe local exercise groups or local charities or something that do run exercise groups locally (PT5: 4: 148) |
| **Role of physiotherapy** | • Procedural information  
                          • Comprehensive explanation | • I talk to my patients a lot; I tell them exactly what we are doing and why we are doing it (PT3: 3: 88)  
                          • I do a lot of talking to them and trying to get them to understand where I am coming from, what I want them to do so they understand the whole big picture (PT2: 4: 169)  
                          • So therefore I can't change that source of the pain, but then I will go on to try and say “as a result your back is stiff”, I will say “those are the things we may be able to have an impact on” you know (PT6: 4: 184) |

**Table 5.8:** Illustrative quotes of conveying information
In conveying information, the participants adopted a range of communication strategies including the use of tests and research, examples of other patients; and the provision of written information (Table 5.9). In prescribing exercises for their patients, the pre-empting of problems was identified as a useful strategy for enhancing adherence.

<table>
<thead>
<tr>
<th>Means of conveying information</th>
<th>Illustrative quotes</th>
</tr>
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</table>
| Using results of tests        | • So I think I try and explain it, the disease process as best as possible to them, you know, getting them to look at their own x-rays (PT5: 3: 95)…  
  • Put the MRI up on the screen and to say “this is your back. There is nothing wrong with your back” (PT1: 6: 234) |
| Using examples of other patients | • You can use examples of other similar conditions you’ve treated in the past (PT9: 4: 186) |
| Pre-empting problems        | • So I try and kind of I suppose give them clear expectation again on what to expect with the exercise because I wouldn’t want them to go away for one day “oh it hurt so I just didn’t do it” you know (PT6: 14: 678) |
| Referring to the evidence    | • I will sometimes throw in the term “research”, you know “all the research shows” …so I’m trying to kind of back up that it’s not just me saying this you know (PT6: 12: 539)  
  • I’ll talk about evidence-based stuff you know I’ll say this is what works, you know everything we do has to be evidence based (PT9: 5: 215) |
| Providing written information | • Sort of giving information out, leaflets they can go and have a look at or letting them know where they can research some of the problems themselves. (PT5: 3: 97)  
  • I try and give them a lot of literature as well so that they can go away and read it (PT1: 3: 122) |
| Using analogies              | • If you had a sprained ankle what would you do? And the same with the back, you know, try and make them think of it as another part of their body (PT8: 2: 64) |

Table 5.9: Illustrative quotes relating to means of conveying information
i. **Concept building in relation to conveying information**

It was evident from the responses of the participants that they considered that the provision of information to the patient was essential for the engaging the patient in their management programme and attaining congruence. Their focus on providing advice relating to the nature of LBP and promoting self-management reflects the current NICE guidelines (2009). Moffett and Mclean (2006:372) have suggested that the explanation to the patient is the “most important and most challenging” component of the physiotherapeutic management of back pain. The physiotherapist has to provide a balanced message incorporating biomedical and biopsychosocial components. It is clear that the participants strived to achieve this approach; however this does need to be considered in light of the limited exploration of psychological issues identified in *interpreting the problem* (Section 5.2.4).

The focus on a biomedical explanation is interesting given the lack of a definitive diagnosis for the majority of LBP. Whilst this could be considered as propagating a biomedical perspective, the approach by the participants has support in the literature. Verbeek, Sengers, Riemens, and Haakfens (2004) found that patients with back pain expect an explanation of their pain from their doctor, and May (2001) and Hills and Kitchen (2007b) found that patients valued an explanation of their problem from their physiotherapist. Liddle et al., (2007) have gone further by suggesting that an accurate diagnosis can validate the patient’s symptoms and favourably influence the overall outcome. Daykin (2006:96) has also argued that a meaningful explanation facilitates patients to participate in their management programme and contributes to a positive outcome. Information about their problem, its management and self-help strategies is clearly valued by patients (Cooper et al., 2008; May, 2007; Verbeek et al., 2004). In addition, there is evidence that an individually tailored exercise programme is appreciated by patients and influences their compliance (Cooper et al., 2008). Reflecting the findings of Cooper et al., (2009), there was no evidence of education in relation to cognitive strategies such as relaxation or distraction.
5.3.4 The communication skills of the clinician

The participants perceived that overall their approach of conveying information to attain a shared goal of management, more realistic expectations and congruity of attitudes towards the role of physiotherapy in managing back pain was successful. Although few issues were identified, it was also recognised that this was dependent on the communication skills of the individual physiotherapist:

*The skill of the clinician to try and manage their expectations (PT6:3: 118)*

There were few examples where the participants appeared to struggle with reconciling perspectives; however as will be discussed in relation to the core category, a considerable number of issues were identified in terms of engaging the patient. It could therefore be construed that at this stage in the process of engaging the patient additional strategies may be required.

i. Concept building in relation to communication skills

The key components of effective communication have been detailed by Maguire and Pitceathly (2002). After determining the patient’s main problems they suggest that the next step is to provide appropriate information based on what the patients need and want to know. Incongruity between the health professionals and patients views on what the patient “needs to know” can mean that information is not understood or retained (Falvo, 2004:76). An assessment of the individual’s requirements would therefore appear to be a useful strategy and not one that was routinely used by the participants. Additionally the Maguire and Pitceathly (2002) suggest that the patient’s understanding of, and reaction to, the information should be ascertained. Again this relatively simple strategy has the potential to pre-empt subsequent issues.

5.3.5 Facilitating and constraining factors

Two factors were considered to be specifically related to reconciling perspectives:

- time;
- lack of co-ordination of services.
Time was identified as a factor that enhanced the ability of the participants to convey information.

_We tend to have more time with them as well whereas some other professions don’t, like a 10 minute GP consultation. They won’t have time to really fully explain it._ (PT5: 4: 133)

_I think listening is probably one of the biggest factors. I know because a lot of the people that they would have seen previous to us they would have probably have been quite short contacts……quite often we can be the first people that they have had a block of time with_ (PT6: 7: 295)

The lack of coordination of services for back pain where patients may see multiple health professionals, constrained the ability of the participants in their endeavours to reconcile perspectives. This frequently resulted in patients receiving fragmented and sometimes contradictory information.

_It’s getting answers from different people isn’t it? I often find they see a consultant for five minutes he tells them one thing; they go to a GP who tells them something different_ (PT7: 11: 402)

i. **Concept building in relation to facilitating and constraining factors**

Literature relating to the information provided by the medical profession to patients with back pain sheds some light upon the issues identified by the participants. In an extensive review of the literature, Kiesler and Auberbach (2006) found that 26-95% of patients considered the information they were given to be insufficient and inadequate. The review looked at studies covering a range of chronic conditions; however the results reflect the findings of a study that focused on LBP. Shaw (2003) found that patient dissatisfaction with the information they received from their General Practitioner (GP) led them to look at alternative sources. This information was frequently contradictory to research findings and contributed to the formulation of unrealistic expectations. Interestingly Shaw (2003) suggested that GP’s are ambivalent about their role in providing information. A recent qualitative study highlighted GP’s uncertainty over the symptoms and credibility of patients with chronic LBP (MacNeela et al., 2010). When combined with the comparatively short consultations compared to physiotherapists and the lack of clinical guidelines, this
may go some way to explaining their rather limited and unhelpful explanations to patients.

### 5.3.6 Understanding and realism

The participant’s perceptions of the results of the process of conveying information are outlined in Figure 5.8, and illustrated with quotes in Table 5.10. The consequences of conveying information were perceived to go beyond that of enhancing knowledge to influencing the patient’s belief system and capacity for self-management. Additionally it was perceived that patient’s appreciate an honest explanation of their problem:

*A lot of people I would say are quite grateful that someone has sat down and spent time with them to explain it* (PT6: 7: 324)

*A lot of patients do appreciate it and say ‘nobody has ever told me that before, I never realised I would never be able to run the marathon’* (PT1: 4: 132)

![Figure 5.8: The results of conveying information](image-url)
Outcomes | Illustrative quotes
---|---
Increased understanding | They understand why they are getting it and why they are receiving their treatment, that sort of thing (PT2: 2: 70)
Empowerment | Just giving them enough information they can make an informed choice as to what sort of things they want to do (PT5: 2: 86)
Realistic expectations | I think if I’ve explained it fully then hopefully their expectations will be more realistic, but it is not always the case (PT6: 7: 318)
| So I think lots of education I think in terms of bringing their expectations down to a realistic level (PT5:3: 106)
Self-responsibility | So it’s more education, get them to have the tools so if the problem comes back again they’ve got the tools there (PT9: 2: 85)

Table 5.10: Illustrative quotes relating to the outcomes of conveying information

i. Concept building in relation to understanding and realism

It is evident that the participants viewed education as integral to their role and vital to attaining congruence with their patients. Definitions of patient education, patient teaching, and information giving are widespread, variable, and often used synonymously (Coates, 1999:4). It is suggested that the term patient education is associated with not just an increase in knowledge but also “behavioural change conducive to health” (Coates, 1999:5). It is evident that the strategies adopted by the participants were primarily related to enhancing knowledge rather than facilitating behaviour change. Whilst it is evident that this has attracted support in the literature, it could be considered that it is based on two assumptions. Firstly it assumes that changes in knowledge, attitudes and beliefs will result in a change in behaviour by the patient. Secondly it assumes that the provision of information is sufficient to result in improved health outcomes (Gravois Lee & Garvin, 2003). Edwards et al., (2004b:70) suggested that objectives of self-management or self-responsibility are associated with high levels of active participation which is developed through “health understanding and behaviour change”. In my study it appears that changes in
knowledge, understanding and beliefs as a result of the provision of information were not assessed, and the extent to which self-management strategies were translated into behaviours did not appear to be evaluated. This has implications for recurrence and health care use.

Human behaviour can be considered as a stream or line of action whereby individuals change their direction in response to new situations or interactions. (Charon, 2004:117). Hence it can be considered that through the process of conveying information to the patient, the patient and physiotherapist will evaluate their decisions, change their minds and create new goals. The potential for the patient to modify their beliefs, attitudes and expectations towards their problem is apparent, as is the potential for the physiotherapist to amend their goals for the patient. As Charon (2004:118) has stated: “what others do in relation to us makes a difference in the decisions we make”.
5.4 Developing an alliance

5.4.1 Introduction

The third and final sub-category was arguably the most important one from the perspective of the participants. The development of a therapeutic alliance with the patient was considered essential to engaging the patient as without it congruence could not be attained and a working alliance established. It is closely related to the previous two sub-categories, facilitating the interactional processes in both. The term “alliance” was adopted after some deliberation. The participants generally adopted the terms “relationship” or “rapport” which appeared to be used interchangeably. A closer exploration of their meaning however revealed a subtle difference. Whilst the former implies an association or connection between two individuals, the latter relates more to trust and mutual understanding. It is possible to have a relationship with someone without necessarily having a rapport. In addition both terms appear to relate more to an affective dimension whereas “alliance” implies a purposeful association which can incorporate an affective element. This appeared to reflect the responses of the participants more closely.

The sub-category was refined from the early open codes of developing a relationship with the patient and getting to know the patient. It was further developed through axial coding which identified three properties:

- relationship: the connection between the patient and physiotherapist and their involvement with one another, it can range from intimate to detached;
- rapport: a close relationship in which the patient and physiotherapist understand each other's feelings or ideas and communicate well, it can range from superficial to deep;
- particularity: getting to know and understand the unique details of the patient (Titchen, 2001: 71), it can range from a collective to individual approach.

In the sub-category, the value attributed to the patient’s experience of physiotherapy represents the condition that leads to the interaction of getting to know the patient. The success of the interaction is influenced by a number of personal and situational
factors. As a result of developing a therapeutic alliance it is considered that the process of care is facilitated and the patient’s experience of physiotherapy is enhanced. The sub-category along with its properties and dimensions is illustrated in Figure 5.9. The findings of the process of axial coding are now discussed and related to developing an alliance along the lines of its properties and dimensions. As in the previous sub-categories, the section is completed by relating the findings to the relevant literature to conceptualise the data.

![Developing an alliance](image)

**Figure 5.9: The results of axial coding for developing an alliance**

### 5.4.2 Value attributed to the patients’ experience

It was evident that the patients’ experience of physiotherapy was important to the participants. They viewed the establishment of an alliance as an integral component of the patient’s whole experience of physiotherapy. This was balanced with recognition of their professional role and this is a recurring theme in this sub-category. The following quote is typical of their support for its importance:
Patient’s experience of treatment is all to do with the respect and rapport they have with a person that’s treating them \( \text{(PT8: 12: 390)} \)

It was generally agreed that a good rapport is less important when managing acute conditions:

\[ I \text{ think some of the conditions sort of maybe like ankle sprains and that kind of thing perhaps it is not so important because they are probably going to get better regardless anyway with time } \text{ (PT5: 11: 451)} \]

Interestingly there was little emphasis on the therapeutic alliance from participants one and two. This may reflect their more diagnostic role as clinical specialists or the fact that the early interviews did not explore this concept. It was initially raised by participant three and hence explored in subsequent interviews.

i. **Concept building in relation to the value attributed to the patient’s experience**

The literature supports the comments of the participants. A lack of appreciation of the influence of the relationship between the patient and clinician on medical outcomes was integral to the development of the biopsychosocial model (Borrell-Carrio, Suchman, & Epstein, 2004). Subsequent models of PCC afforded the relationship greater priority. The therapeutic alliance was one of five dimensions of patient-centredness identified by Mead and Bower (2000). In their model the relationship between the doctor and patient was regarded as a “fundamental requirement” to PCC, as opposed to a “useful addition” in a conventional biomedical approach (Mead & Bower, 2000:1090). Stewart and Brown (2003:121) concurred stating that it is the “foundation for patient-centred-care”. They went on to suggest that it is the quality of the relationship, one that is unique to each individual relationship, which provides the basis for a mutual understanding and agreement of the patients’ problem and its management. The emergence of relationship-centred care has placed further emphasis on healthcare relationships, particularly the affective and emotional dimensions of this liaison (Beach & Inui, 2006; Borrell-Carrio et al., 2004).

Studies also support the importance attributed to the therapeutic alliance by physiotherapists and patients. Stenmar and Nordholm (1994) found that Swedish
physical therapists considered treatment success to be related more to the relationship between the physiotherapist and patient, rather than to the treatment they provided. Gyllensten Gard, Salford, and Ekdahl (1999) supported this finding. In their study, the participants emphasised the quality of the interaction over therapeutic techniques. However it should be noted that the participants were physiotherapists who were considered to be “experts” in terms of interaction. Resnik and Jensen (2003) found that the patient-centred practice of expert clinicians was characterised by the cultivation of a relationship with their patients. From the perspective of the patient, the establishment of a good relationship was integral to the transformative spiral of confidence, motivation and progress proposed by Kidd et al., (2010).

Finally, as previously discussed (Section 5.2.6.1), the meaning of the patient’s problem is constantly re-negotiated within the therapeutic relationship providing the opportunity for the therapist to positively influence this process (Parry, 2004a:71). It could be therefore be postulated that the quality of the therapeutic alliance will influence the process of meaning construction by the patient (Blumer, 1969:69).

### 5.4.3 Getting to know the patient

The development of a therapeutic alliance was characterised by an individualised patient-specific approach. Getting to know the individual patient in the context of their personal life was perceived to facilitate the participants to explore the factors that may be contributing to the patient’s problem:

> So sort of getting to know them as a full person and their life and what is going on (PT4:2: 58)

> Whereas if you get to know them a little bit first, rather than just firing in straightaway, once you have got to know them a little bit, you have built up a rapport, you can ask it maybe a little bit more tactfully (PT5: 7: 287)

To this end, it was evident that the participants utilised a considerable range of verbal and non-verbal strategies. These are outlined in Figure 5.10 and illustrated with quotes from the participants in Table 5.11.
Social conversation was frequently adopted to learn about the individual patient. This often revolved around topics such as family, travel and sport. A shared interest was considered a useful vehicle for enhancing the rapport with the patient beyond the superficial level. The attributes of sympathy and empathy received some attention from the participants although this was not elaborated upon in great detail and the terms tended to be used interchangeably. Certainly the personal experience of back pain assisted participant eight in understanding her patients whilst participant seven indicated that her lack of experience of severe back pain influenced her ability to engage with her patients:

- *It’s much easier to empathise or to understand something you’ve had that type of problem with* (PT8: 13: 453)

- *Probably I’m not as sympathetic maybe because I’ve not had severe back pain* (PT7: 7: 261)

Listening to the patient was identified as key to the assessment of the patient (Section 5.2.3.) and it was frequently highlighted as an important skill in developing a rapport. Finally, it was evident throughout the interviews that the participants cared about their patients and strived to manage their back pain in the most appropriate way. This was articulated on a personal and professional level:
It is just trying to find things that are going to be of benefit to them  
(PT5: 5: 202)

I think we have also got a responsibility to do our very best for that patient  
(PT3: 3: 126)

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<th>Verbal strategies</th>
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<tr>
<td>Social conversation and self-disclosure</td>
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| • Just kind of if you find something you have in common that you can sort of talk to them about  
  (PT5: 11: 465) |                                                                 |
| • I will find out a little bit more about their background, their family dynamics by probably giving them a little bit about my family dynamics and things  
  (PT4: 2: 55) |                                                                 |
| • I’ve learnt to talk about a lot of things, a variety of topics you know, and try and build up a rapport that way  
  (PT6: 9: 417) |                                                                 |
| Non-verbal strategies              |                                                                 |
| Sympathy and empathy               |                                                                 |
| • It all revolves around talking to them and being empathetic and sympathetic  
  (PT3: 4: 151) |                                                                 |
| Monitoring and evaluating          |                                                                 |
| • I think you pick up a lot on body language and a lot on their responses to questions, you know, just how chatty they are, that sort of thing  
  (PT4: 2: 85) |                                                                 |
| • Some patients, treatment time is very quiet and some treatment is very noisy, I think it is basically what you get back from a patient  
  (PT3: 4: 169) |                                                                 |
| Sensitivity                        |                                                                 |
| • I think you have to gauge what kind of personality they are and almost match it to a certain extent. So if they are very bubbly, lively person then you can sort of reflect that really and that way I think you can sort of build up a good rapport  
  (PT5: 11: 459) |                                                                 |
| Listening                          |                                                                 |
| • I think that is the main thing I find in certain patients they kind of come across as quite aggressive and if you actually sit and listen to what they are sort of talking about and what they are saying…(PT4: 6: 225) |                                                                 |
| Professionalism                    |                                                                 |
| • You have got to be polite to them and courteous and be professional as well  
  (PT3: 4: 143) |                                                                 |
| • I think non-verbally as well, being welcoming when they first come in and making a good impression, sort of being polite and being professional  
  (PT5: 11: 468) |                                                                 |
| Informality                        |                                                                 |
| • So speaking on their terms, their language  
  (PT7: 10: 365) |                                                                 |
| • I’m professional, I don’t try and be too formal sometimes because it scares them  
  (PT7: 10: 364) |                                                                 |

Table 5.11: Illustrative quotes for verbal and non-verbal strategies
i. **Concept building in relation to getting to know the patient**

The concept of particularism and universalism in client-practitioner relationships was first proposed by Parsons (1951) and related to contemporary health-care relationships by Best, Cant and Ryan (2001). Parsons (1951:454) believed that the relationship should be characterised by universalism, the application of a set of professional principles, rather than a focus on the individual. The participants in this study clearly balanced their professional role with a more individual approach. To this end it is evident that they adopted a variety of communication skills in order to facilitate a therapeutic alliance. Swain (2004:12) suggested that “*relationships between physiotherapist and client are defined or maintained through the communication between them*” and the positive influence of effective communication skills is supported in the literature (Gyllensten et al., 1999; Kidd et al., 2010; Klaber Moffett & Richardson, 1997). Reflecting the responses of the participants, listening and empathetic understanding are considered particularly influential (Gyllensten et al., 1999; Reynolds, 2004b:116). In the patient-centred clinical method (PCCM), empathetic identification was highlighted as vital to enhancing the patient-doctor relationship (Stewart & Belle Brown, 2003:119) and empathy was a fundamental tenet of relationship-centred care (Beach & Inui, 2006). Daykin (2006:94) has urged physiotherapists to convey empathy and affirms the approach taken by the participants by suggesting that active listening is a way to facilitate this process.

It is evident from the literature that patients value such attributes. The ability of health professionals to relate to the patient and to demonstrate an empathetic understanding has been highlighted within medicine (Mercer & Reilly, 2004) and physiotherapy (Cooper et al., 2008; Kidd et al., 2010). Patient satisfaction studies confirm that patients value friendliness and empathy (May, 2001). In addition poor outcomes are associated with poor listening skills and a lack of empathy (Hills & Kitchen, 2007a).

The value of caring is reflected in the study by Resnik and Jensen (2003) where therapists classified as both expert and average expressed a desire to help others. Similarly, a survey of the basic values for physical therapists by Noose and Sagiv
(2005), found that the respondents to their survey rated benevolence as the most important value in guiding their behaviour. The authors suggested that this supports the importance of caring in the relationship between the patient and therapist.

5.4.4 **Personal and situational factors**

Overall the participants perceived that the development of an alliance presented them with few issues. The influence of the physiotherapist as a person and the preferences of the patient were however recognised as potential confounding factors. The personal situation of the participant attracted some attention:

_I think probably as well even personal things that are going on in the therapist’s life can affect how empathetic or patient we can be with patients as well_ (PT6: 7: 264)

It was also evident that their personal opinion of a particular patient may also impact on their ability to develop an alliance:

_Those are the ones I’ve got less patience for if I can see they are playing the system and there are a few like that that really annoy me_ (PT9: 7: 346)

_You get those patients you think “oh no they’re coming” and you do get like that and I suppose that’s human nature to a point_ (PT7: 9: 338)

It was recognised that some patients preferred a detached relationship and were more focused on the treatment process:

_But there are a few patients that I have generally you can sort of feel that they are very much, they have come for a specific thing, they want to get that over and done with and they want to leave_ (PT4: 2: 89)

In such cases the participants indicated that they persevered with the strategies identified in developing an alliance before accepting that this was not going to be possible:

_There are some people that are really hard to break and actually get to know and I will try for one or two sessions or so and then I will find if I’m not getting any kind of response from them I won’t push it and then it may become a little bit more, I suppose prescriptive is the word_ (PT6: 8: 371).
Talk about something else, something may come out .......you can’t force a rapport can you? (PT8: 11: 379)

Whilst a rapport and relationship was considered positive in terms of engaging the patient, it was also evident that the participants were careful to balance this with their professional role. This may be because they perceived that a deep affinity and intimate relationship could potentially undermine their role:

There is obviously a line to be drawn between being professional and overstepping the boundary (PT3: 4: 147)

Because then I might not be able to direct what I want them to do (PT8: 11: 356)

An alternative explanation is that a close relationship can lead to issues from the perspective of the patient and physiotherapist:

Some patients do rely quite heavily on you and I think that is because they come and see you every so often they build up a rapport with you (PT1: 9: 385)

Once I build a rapport with a patient and I’ve started treatment, I find it very difficult to let them go into a class (PT8: 13: 431)

i. Concept building in relation to personal and situational factors

In the universalism view of the client-practitioner relationship the practitioner applies their skills regardless of the individual client (Best et al., 2001). It was evident in this study that the participants’ practice was influenced by their own personal situation and perspective of the patients. The potential influence of these issues on the development of an alliance is unknown and the extent to which it can be addressed is uncertain. Best et al., (2001:106) have suggested that it highlights the requirement for health professionals with a “diversity of personal characteristics” although they do not elaborate on this recommendation. In addition they advocated the importance of personal and professional support in the workplace. The perceived influence of the physiotherapist themselves was affirmed by Daykin (2006:100) who suggested that the “mood” of the clinician is the greatest barrier to effective communication.
Parsons (1951:435) considered “affective neutrality” on behalf of the physician to be a requirement for healthcare consultations. In this approach the physician maintains an emotional detachment from the patient. It is evident from my study that the participants did not value such objectivity; however they also were careful to maintain a boundary between themselves and the patient. The consequences of a close relationship and the issues it raises for the participants were discussed by Szybek et al., (2000). By applying the components of the psychotherapy relationship to physiotherapy, the authors illustrated how transfer configuration can impede physiotherapy management of a patient. Transfer configuration is a combination of transference (where the patient relates to the physiotherapist in a repetition of earlier relationships) and countertransference (where the physiotherapist relates to the patient in a repetition of earlier relationships). The last two quotes by the participants could be considered to illustrate situations of high transference with the patient adopting a child-like role for participant one and participant eight acting out the role of an authoritarian who knows what is best for the patient. An alternative explanation relates to attachment. In the first quote the patient has become dependent upon the physiotherapist. In the second quote it appears that the physiotherapist is so involved with the patient that they feel responsible for their recovery. Hence they find it difficult to pass over the patients’ recovery to the therapist who runs the class, and to “let go” of the patient.

It is suggested that physiotherapists should be aware of transference and how to address it. However this requires longer treatment sessions and additional training (Szybek et al., 2000). Additional training in counselling and communication skills alongside clinical supervision and the support of a team is also recommended to enable the therapist to “invest” themselves in the therapeutic relationship (Reynolds, 2004b:129).
5.4.5 Facilitating and constraining factors

Three factors were considered to be particularly influential in facilitating the development of an alliance:

- interpersonal and communication skills of the physiotherapist;
- time;
- continuity of care.

It was evident that the participants perceived that their own interpersonal and communication skills were influential in developing the therapeutic alliance. There was a general belief that they had well developed interpersonal and communication skills. The latter was frequently associated with being a physiotherapist:

I think I am quite a good interactor with the patients    (PT6: 5: 38)

We’ve got a good way of empathising with patients. You know I think we are very good at that you know. Don’t know whether it’s the type of person that wants to be a physiotherapist, how we’re educated at college and I think it’s got a lot to do with who you are as a person and I think yeah we’re very good at that    (PT9: 6:294)

It was recognised that the ability to build up a rapport with the patients was a skill that may be easier for some therapists than others and that it was integral to their professional role:

I think it is more than one skill, it is a collection of things and I think it comes more naturally to some people than it does to others    (PT3: 4: 150)

I think there are a few of those physiotherapists that no matter what you do they will never be able to build up that sort of rapport and it may not be the best profession for them or the best area    (PT4: 4: 155)

The participants acknowledged that the time they were able to spend with patients was contrary to the patient’s experience with other health-care professions:

I think we get more time which is a big factor. I know for us we say we don’t get much time but I think we get a lot more time compared to other practices    (PT9: 6: 292)
Despite this it was evident that they felt pressurised to complete their initial assessment and identify the patient’s problems in the time available. This related both to the demands of their professional role and to external factors:

_"I mean time for us is a big factor. It is an issue with us........waiting list pressures, time, admin (administrative duties), new systems coming in" (PT9: 10: 477)_

Interestingly, the issue of “triage” appointments attracted some differences of opinion. In response to waiting list pressures, “triage” appointments were introduced in the Trust. This meant a reduction in the time for an initial assessment from one hour to 30 minutes. Participants who were unfamiliar with this approach clearly found the system challenging and indicated that it compromised their ability to be patient-centred:

_In my experience I found it very frustrating to have to get so much done in such a condensed space of time and very often I found I wasn’t getting a full picture_ (PT3: 2: 59)

Triage was integral to the role of the participants who were clinical specialists and in contrast their perceptions were much more positive. They indicated that the patient’s experience would be comparable:

_"I think they would get the same type of advice and the same treatment overall" (PT1: 7: 285)_

_Continuity of care_ was also identified as a factor that was pivotal in developing an alliance. It was generally considered that most patients were happy to build a rapport with their therapist although this may involve a temporal element:

_"So they’ll come back a few times and having seen them a few times you find they open up a bit more" (PT7: 10: 362)_

Again the participants contrasted the experience with physiotherapy to that with other health professionals. Potentially patients may have seen their general practitioner, an orthopaedic surgeon and a specialist physiotherapist before finally reaching the out-patient physiotherapy service. The participants indicated that this was less satisfying for both the patients and for the physiotherapist:

_"I think it is important to have that relationship and to see them through it which I value" (PT7: 10: 392)_
I think again also a lot of the feedback that you get from patients is when you go and see an orthopaedic consultant that they see a different person every time, so they don’t ever feel they’re with someone that knows them and understands their condition (PT6: 9: 426)

The department in which the participants worked considered continuity of care a priority. However if continuity was compromised through sickness or rotation of staff for example, the additional pressure on the participants was evident:

I think that’s (continuity of care) really important actually you know that’s something we try and do here as much as possible (PT6:9: 423)

You often don’t understand the physio’s notes very well so you’re trying to build up a rapport within a couple of minutes (PT8: 12: 406)

i. **Concept building in relation to facilitating and constraining factors**

It is evident that personal and situational factors were considered to influence the development of the therapeutic alliance. Effective communication skills were identified as facilitating the therapeutic alliance and this factor is discussed in more detail in relation to the core category. Time was identified as vital to the development of an effective therapeutic alliance. It is recognised that physiotherapists spend more time with their patients than other healthcare professionals enabling them to create deeper relationships (Petitpas & Cornelius, 2004). Whilst the issue of time is discussed extensively in relation to the core category, the perspective of the clinical specialists in relation to “triage” is worthy of consideration in relation to developing an alliance. The role of the clinical specialist in triage is largely that of screening. In contrast to the goal of “self-management” for physiotherapy, the clinical specialists have a different remit. They assess patients to identify the most appropriate destination for onward referral. Consequently, their assessment is almost entirely biomedical in focus and less reliant on patient “engagement” for its success. Whilst the specialists may ultimately take on the patient for treatment in the out-patient department, this is not guaranteed. Hence their comments regarding the patients’ experience of triage should be considered in this light.
Reflecting the views of the participants, the importance of continuity of care is supported by patients. Payton, Nelson and St. Clair Hobbs, (1998) found that patients perceived that their relationship with their therapist evolved over time particularly in terms of friendship, trust and respect.

5.4.6 A positive patient experience

There was general consensus that the quality of the alliance had far reaching consequences on the therapeutic process and resulted in a positive experience for the patient (Figure 5.11).

![Diagram: The consequences of the therapeutic alliance]

Figure 5.11: The consequences of the therapeutic alliance
Trust was by far the most valued outcome of the alliance. The participants perceived that a trusting relationship was vital for influencing the patient’s belief and self-efficacy in their management programme

*It is essential that they trust you; they believe you and believe that they’re trying to do something to help* (PT8: 11: 360)

*I need to kind of win over their trust a little bit I think so they are actually going to go home and believe what they are doing is going to make a difference* (PT5: 4: 169)

A trusting relationship also facilitated patients to “open up” so the participants could attain a greater insight into their personal lives.

*It’s kind of that unspoken trust isn’t it with the therapist. You know you tend to tell them everything type thing* (PT7: 9: 351)

The alliance with the patient assisted in agreeing a plan of management, particularly where there were perceived to be issues:

*I think it’s (a rapport) is vital really because then if there are some areas where you don’t necessarily agree on what treatment should be done then you know if you’ve got a better rapport with them you may, you know, when you actually explain exactly why you’re doing things, they may be more understanding of that* (PT6: 8: 368)

It was also evident that the participants perceived that an effective alliance enhanced compliance:

*If you haven’t really got that much of a relationship then it is all a bit distant. I think you are probably going to struggle really to get them to buy into those ideas, to be more compliant with those bits of homework* (PT5: 11: 448)

*I think it does make a big difference because they are going to go with you in what you do and they are going to be more compliant on the whole if you have got them on board* (PT4: 8: 368)

Whilst the participants were convinced of the beneficial effects of the alliance on the management process, its impact on outcomes elicited mixed responses:

*So I think to a point it’s hard to get the most optimum response from them if you don’t get that relationship with them* (PT7: 9: 352)
I don’t know to which extent it affects the outcome. I don’t know (PT8: 12: 387)

There was little discussion regarding the consequences of a poorly developed alliance. It was however evident that the participants found this a less satisfying experience and perceived it to be less fulfilling for the patients.

If you’re not getting anything back from them, you can’t persist with that kind and it probably becomes less patient centred I would say (PT6:8: 378)

I think there are lots of patients who don’t turn up again if they’re not happy with the way they’re dealt with (PT8: 12: 391)

i. Concept building in relation to a positive patient experience

The considerable influence of the physiotherapist-patient relationship on the process of care was highlighted in a review article by Klaber Moffett and Richardson (1997). Its positive effect on compliance, adherence and self-efficacy were related to psychological theories of health belief and self-efficacy. More recently a systematic review revealed that the relationship had a positive association on a number of outcomes for musculoskeletal conditions including treatment effect, pain, physical function, satisfaction, depression and general health status. However only three of the studies included in the review specifically related to LBP (Hall, Ferreira, Maher, Latimer, & Ferreira, 2010).
5.5 The core category – engaging the patient

5.5.1 Introduction

Engaging the patient in a working alliance emerged as the core category as it appeared to fit all the criteria for such a role. It appeared frequently in the data and was the central event to which the other sub-categories were related. In the context of this study, the term “engaging” refers to the extent to which the patient participates in their physiotherapy management. It can be viewed as the culmination of the physiotherapists’ interpretation and reconciliation of the patient’s problem and is facilitated by the therapeutic alliance. The core category was initially termed congruence, followed by interactional congruence. Although closely related to the other sub-categories the properties of participation and decision-making, developed through axial coding, differentiate this category from the others:

- participation; the patient takes part in their management; the extent of the involvement can range from involvement through collaboration to partnership (mutuality);
- decision-making: the process of making choices, this can range from paternalism through sharing to informed (patient led).

The properties are closely related with high levels of participation being associated with informed decision-making and vice versa (Figure 5.12).

![Figure 5.12: Continuum of decision-making and participation (adapted from Thompson, 2007)](image)

The participants’ goal of self-management for their patients necessitates that the patient is an active participant in their care. This represents the condition that leads to the interaction of “engaging the patient. The action and interactions in this category are all related to selling this concept to the patient. The process of engaging the
patient in their management is not always straightforward but associated with a considerable number of issues which have to be managed. In common with the sub-categories, a number of factors serve to facilitate or constrain its development. Successful engagement of the patient culminates in a “working alliance” whereby the patient and physiotherapist form a collaborative partnership. The core category along with its properties and dimensions is illustrated in Figure 5.13. The findings of the process of axial coding are now discussed and related to engaging the patient along the lines of its properties and dimensions. As in the sub-categories, each section is completed by relating the findings to the relevant literature to conceptualise the data.

![Figure 5.13: The results of axial coding for engaging the patient](image)
5.5.2 “They should be involved from the word go” (PT4: 2: 52)

The above quote indicates the importance attached by the participants to patient participation in the management programme. As discussed in relation to *interpreting the problem* (Section 5.2.3.), “self-management” was the participant’s goal of physiotherapy. Consistent with this view of their role, the participants perceived that the patient’s role was to engage with the management plan. There was an expectation that patients would co-operate with intervention programmes and non-adherence was perceived as inconsistent with the goal of physiotherapy:

> So if by the next time this hasn’t been done or that hasn’t been done, then we will review whether physiotherapy is the right kind of thing for you to be doing (PT5: 10: 429)

In terms of extent to which the patients' participated in their management, this appeared to be more focused on the involvement end of the dimensional continuum rather than a mutual partnership:

> Involving the patients listening to the patients and trying to respond to their needs (PT6: 6: 285)

i. **Concept building in relation to patient involvement**

The emphasis on self management and self-responsibility is in accordance with the most recent guidelines for the management of persistent low back pain (LBP)(NICE, 2009). In an overview of best practice for physiotherapy, Moffett and McLean (2006) also stress the importance of active self-management to encourage the resumption of normal activities. Over a decade ago, Watson (1996) urged neuromusculoskeletal physiotherapists to move from an approach which focuses on symptom relief, to one which encourages self-responsibility. It is evident that the intervening years have seen a considerable shift in the focus of management for patients with LBP. The approach of the participants reflects the role of the physiotherapist as an “enabler”, a term adopted by Klaber Moffett (2000) to indicate that the resumption of normal activities should be the goal of physiotherapy for patients with musculoskeletal
conditions. Ferguson et al., (2008) also found that enabling self-management was a point of strong consensus between expert physiotherapists.

It is suggested that collaboration in clinical practice has increased in importance as a result of the changing environment of health care (Edwards et al., 2004b). Whilst it is variously termed “sharing power and responsibility” (Mead & Bower, 2000:1089), “finding common ground” (Belle Brown et al., 2003c:83) and “collaborative problem solving” (Resnik & Jensen, 2003:1098), its significance is reflected in its inclusion in all the relevant models of patient-centred care. From the patient’s perspective, Verbeek et al., (2004), found that patients expect advice regarding management of their back problem from their healthcare professional. More specifically to physiotherapy, May (2001:14) found that patients wanted “a level of consultation”, in which the therapist listened and responded to their questions and involved them in the treatment process. It also appears that a positive attitude to self-management may be related to outcomes. In a questionnaire-based study, Larsson, Kreuter, and Nordholm (2010b) found that patients who believed that that should assume an active role in their management, were more likely to report a better outcome from their physiotherapy treatment.

Whilst the goal of the participants was to enlist their patients as collaborators it could be considered that this was at a relatively basic level. Thompson (2007) posits that involvement could be conceived as a precursor to collaboration, with partnership as the ultimate joint venture. Such a transition requires decreasing the knowledge gap between the health professional and patient and some conceding of power. The next section explores the means by which the participants strived to engage their patients and provides some insight into perhaps why the level of patient participation appears to be limited.

5.5.3 Selling the idea

The role of the physiotherapist was compared to that of a sales person and that was reflected in the actions and interventions adopted by the participants to facilitate patient engagement:
You are selling an idea and they need to put the idea into practice
(PT9:4: 194)

Broadly the “marketing” strategies could be categorised as those relating to the skills and attributes of the physiotherapist as a person and professional and those related to the goals and priorities of treatment (Figure 5.14). The concept of exploring goals could be considered to be at the heart of the core category and hence this is explored in detail.

![Diagram of Selling the idea]

**Figure 5:14: Selling the idea**

**i. Using personal skills**

The participants’ respect for their patients as individuals and their own personal attributes, including flexibility and reflectivity, could be viewed as strategies that would facilitate the patient to engage with their management. Typically they viewed the patient as a person rather than a patient. To this end, they often found it difficult to
articulate their approach to managing the patient’s problem as it was so dependent on the patient:

*I am seeing them as a person rather than just you have got a bad knee, you have got a bad back and L4 (4th lumbar vertebrae) is not working properly* (PT4:7:301)

*I think it really depends on the patient rather than having one strict…it’s not like with every single patient I see I will do the same thing* (PT3:1:27)

Adapting interventions to the individual was a common strategy and the term “tailoring” was frequently expressed. Typically they took time to ensure that interventions, exercises and advice were individualised:

*Interventions need to be tailored around the individual patient so that you can’t just get one model and apply it to everybody.* (PT1:3:94)

*So you’re tailoring it to that particular person. You’re treating the person. Often as well as the back problem, you’re treating the person* (PT8:4:109)

The participants clearly valued the patient’s autonomy and where possible integrated their perspective into their management plans:

*Sometimes they want a treatment because somebody has had it done and they think it is going to work for them and as long as it is suitable I would never deny that* (PT1:3:104)

*We do acupuncture here and people come in and say “I have heard acupuncture is good for back pain” and you say “we will give it a go”* (PT2:4:160)

Such an individualised approach necessitates a flexible and responsive therapist and this was evident in the initial assessment of the patient, their clinical reasoning and decision-making. In response to a lack of patient engagement, some participants were prepared to modify their approach completely:

*You know there are patients I really think I can’t find any real mechanical kind of cause or need for treatment and I want to take kind of the active approach, and they just really aren’t committing with it you know, committing to it, then I might try hands on and just see where it gets me* (PT6:7:338)
In contrast, others were less prepared to do this:

*If you know something is not going to be effective with a patient, you can't just do it because the patient wants it. That's not what we do*  
*(PT9: 9: 429)*

Flexibility was also evidenced by the way the participant's modified their management to maximise the use of resources. In response to the limit of six treatments sessions, they spread them out to allow time for self-management strategies to be effective and for the natural healing process to occur:

*So what we have been having to do now is actually sort of space the treatment out a little bit more so that we can see them over a three or four month period*  
*(PT4: 8: 333)*

Reflective practice was also evident in the responses of the participants. Whilst some participants discussed this overtly, for others it was apparent in their descriptions of how they improved and refined their practice:

*Probably having bad experiences or not dealing with something as well and just reflecting on the times where I haven't dealt with things properly*  
*(PT1: 10: 397)*

*You see also among your peers, the few ESP's (Extended Scope Practitioners) we have here, what you see works and you're obviously influenced by them*  
*(PT9: 2: 98)*

Participant nine highlighted the value of reflection on practice, but indicated that with a busy caseload, this was challenging for more junior grades. The most junior of the participants acknowledged this and grasped opportunities for reflection where she could:

*You've got to reflect while you're doing something and you can't you know, they're trying to get the techniques down, you're trying to assess, trying to get your measurements*  
*(PT9: 11: 531)*

*I love it when I've got a cancellation because I can sit back, I can think about the patient I have seen, I can think about and plan what I want to do for next time*  
*(PT7: 16: 613)*
ii. **Exploring goals**

It was evident from the participants that the formulation of goals of management was considered integral to engaging the patient. This involved a two stage process. The first stage was closely linked to *interpreting the patient’s problem* whilst the second stage involved a more explicit attempt to integrate the patient’s perspective.

a. **Identifying goals**

This could be considered as an extension to the cognitive process of *interpreting the patient’s problem* and the influence of the discourse of the profession was obvious. The terms subjective, objective and functional goals were commonly expressed and it was evident that the participants viewed their goals as the ones that had to be achieved for the patient’s goal to be successful:

*In my mind I set a subjective, an objective and a functional goal. So the subjective and functional are to do with the patient and that comes from what they have told me in the subjective. ….the objective goal is probably more for me …the functional is a bit of subjective and a bit of patient-centred*  
(PT1: 12: 492)

*I think a lot of the time we need to achieve the physio goals in order to achieve their main, their sort of perhaps overall functional goal*  
(PT5: 2: 76)

It was considered important to identify goals to delineate the role of physiotherapy:

*And they might want to carry on with physio, but if you can sort of demonstrate “well this is what you set out to achieve and we have done that now”. So it’s trying to stop them moving the goal posts really*  
(PT5: 5:12: 484)

The emphasis on a functional goal was consistent across all the participants and this was closely linked with their individualised approach to their patients:

*So more about function but tailored individually to every person and everyone will be different depending on what their lifestyle is*  
(PT3: 3: 109)

This was coupled with the recognition that complete pain relief was unlikely:

*Their pain may not necessarily get better, but in their functioning they should get some improvement*  
(PT1: 3: 123)
b. Involving the patient in decisions

The extent to which the participants involved the patient in decisions around goal-setting was very variable. This was an issue that attracted a considerable amount of discussion and it is evident that there was a level of tension in this endeavour. Table 5.12 illustrates the range of responses from the participants.

Whilst the majority indicated that a shared approach was their preferred means for engaging the patient, inconsistencies were evident both within and between participants, with a leaning towards a therapist – led approach. There was little evidence of a primarily patient-led model with the exception of participant four; however this participant also expressed what could be construed as a dictatorial approach to the use of classes.

The topic of choice of treatments attracted a lot of discussion. It was evident that the participants offered choice where they could. Choice was available when it came to the use of specific modalities for pain relief e.g. acupuncture and transcutaneous nerve stimulation (TNS), however it was apparent that this was more often in relation to the therapist’s plan of management. Consequently it could perhaps be considered more of a perception of choice, situated at the lower end of the participation continuum:

*I would say “what exercise suits you because not every exercise suits you” and then I might say “Are you a swimmer? Do you like walking? Are you a member of a gym?” (PT6: 13: 605)*

*I know that they need to exercise and I suppose there’re some people who don’t want to exercise but at least I’m trying to the find an avenue that might suit them..........So I will try and ask them “OK what type of exercise will suit you most?” and then I might base the goals around that (PT6: 13: 609)*

In terms of the overall management of LBP the participants recognised that the extent to which they could offer choice was limited:
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<tr>
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<th>Therapist - led</th>
<th>Shared / Involved</th>
<th>Patient – led</th>
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<tbody>
<tr>
<td>1</td>
<td>Some patients will say “I want to be able to do this” and I will incorporate that. I may not formally say that to them, right this is going to be your goal, but I will incorporate that depending on what they say to me or how many times they say it. (PT1: 12: 516)</td>
<td>Basically if it is a management approach they need to be in charge of their own destiny, their own exercise programme and stuff and if they are not switched on, not involved, not involved in choosing the programme then I don’t think they are going to do it. (PT2: 5: 171)</td>
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<td>2</td>
<td>The patient themselves is given the treatment that is the best thing for them and they understand why they are getting it and why they are receiving their treatment (PT2: 2 69)</td>
<td>So rather than things being put on them, decision-making by the patient in conjunction with the therapist. (PT3: 1: 41)</td>
<td>Then coming to making goals I say to the patient “what is important to you? What do you want to get out of physiotherapy? What do you want to achieve?” (PT3: 3: 103)</td>
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<td>3</td>
<td></td>
<td>Making sure we discuss what we want to achieve sort of in conjunction with what their achievement wants to be as well and making sure we sort of hit some middle ground (PT5: 2: 75)</td>
<td>It means they should take the lead as to what they want us to achieve and they should be involved from the word go (PT4: 2: 52)</td>
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<td>4</td>
<td>But there are patients that want to have hands on treatment and have one to one therapy that we put into classes because we feel that clinically that is where they should go (PT4:12: 518)</td>
<td>I see it as kind of working with the patients to try and help them achieve what they want to achieve (PT6: 8: 281)</td>
<td>I try to get them to come up with it rather than putting words in their mouth (PT5: 6: 220)</td>
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<td>5</td>
<td></td>
<td>What are you hoping to achieve from physio? What does that do? What are you intending it to do for you? and I’ll often ask that question at the initial assessment and try and set a goal with them (PT7: 4: 136)</td>
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<tr>
<td>6</td>
<td></td>
<td>I do get them to cooperate or agree to what we’ve decided to do (PT8: 7: 218)</td>
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<td>7</td>
<td></td>
<td>I think it is up to us to decide what’s best for them treatment wise (PT9: 9: 420)</td>
<td>To get that understanding between us, like that mutual contract, what is going to happen (PT9: 5: 235)</td>
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</table>
I always try to work towards their goals and things but in terms of actually the way that we get there, we are limited on what services we can offer (PT6:16:767)

I suppose they don’t get much choice when they come to us really. They’re here to take it or not (PT7: 14: 534)

It was evident that some of the participant’s perceived that patients do not necessarily value choice. This was linked to the participant’s perspective of their own professional role and their perceptions of patient expectations:

I think they want to go and see someone and someone to assess them and say this is what I think is wrong, this is what I think needs doing’ and I think they want someone to give them that (PT2:4: 133)

You are giving your professional opinion that this is what’s right for them (PT6: 11: 515)

iii. Using professional skills

The personal approach of the physiotherapist and exploring goals and priorities of management have been presented as the two dominant strategies for engaging the patient in their management and establishing a working alliance. Several other strategies were also identified and these appeared to relate to the professional skills of the physiotherapists. The clinical specialists, for example, had the advantage of being able to order tests which they could utilise to provide evidence to the patient that there was nothing wrong with their back and that engaging in the self–management programme was the way forward. Whilst it was recognised that this may not be warranted clinically, it could be justified if it helped the long term recovery of the patient:

There is a lot of demand now for MRI scans and we are sometimes doing them, one not necessarily because we think there is a problem, but to say ‘we have scanned you, there is nothing seriously wrong, this is something you should manage’ (PT2: 3: 109)

Using their expertise was also recognised as a valuable strategy. If the patient obtained some benefit from implementing the therapists advice or exercise programme, then it was considered that this would facilitate them to engage further:
If they can see a result or they can see an effect say after treatment then they're more inclined to maybe keep working at it. So I think that's quite important (PT7: 14: 513)

iv. **Concept building in relation to selling the idea**

My perception is that *selling the idea* of a self-management approach is integral to *engaging the patient*. A considerable number of actions and interactions were focused on this concept. Although it did not appear as a distinct entity in any of the literature relating to PCC, having identified the concept I discovered a considerable body of evidence from different sources which assisted in its conceptualisation. This literature is now related to *selling the idea*. As this is a lengthy discussion, it is broken down into several sub-sections:

a. The influence of the physiotherapist as a person
b. Exploring goals of management
c. Guidance available for goal-setting
d. The practice of goal-setting
e. Models of goal-setting
f. Involving the patient
g. Resolving issues with goal-setting
h. The patient's perspective

a. **The influence of the physiotherapist as a person**

Cusick (2001:91) suggests that the professionals are people “long before they become professionals” and the influence of a health professionals personal qualities is recognised in the patient-centred clinical method (PCCM) (Stewart & Belle Brown, 2003:118) and by Mead and Bower (2000:1090) in their dimension of the “doctor as a person”. Beach et al., (2006:S4) have argued however that this concept of personhood has “been underdeveloped in most accounts of patient-centredness”. Within physiotherapy, the competence and personality of the physiotherapist was identified as a discreet dimension by Cooper et al., (2008) however it was less overt in the findings of Kidd et al., (2010). Individualised care was evident in the clinical practice style of the “expert” practitioners (Resnik & Jensen, 2003) and the participants in my study, whilst not classified as experts, clearly also valued this aspect of their care. This is supported
by patients. Individualised management plans that address the varying needs of patients are key to patient satisfaction (May, 2001) and appear to influence compliance (Cooper et al., 2008).

The concept of reflective practice, including its key elements of reflection-in-action and reflection-on-action (Schön, 1983), is widely recognised in the health professions. It is suggested that the construction of meaning through social interaction is modified through reflection and hence may change over time in response to new social interactions (Abrandt Dahlgren, Richardson, & Kalman, 2004:16). Professional development is therefore a continuing process, whereby new experiences with patients bring new opportunities for reflection (Cusick, 2001:92). Reflective practice has been identified as integral to PCCM. Stewart and Belle Brown (2003:125) highlighted the importance of self-awareness in the PCCM. They indicated that reflection on experience and discussion with colleagues increased self-awareness. It can be enhanced further by personal and professional experience and by learning from others. Self-awareness, through exploring our own worlds and reflection on what we bring to and take from individual therapeutic encounters, is also one of the four principles of relationship-centred care (RCC) (Beach & Inui, 2006; Dobie, 2007). Within physiotherapy it is recognised that the development of knowledge is facilitated by reflection and a working environment that encourages therapists to learn from their colleagues (Resnik & Jensen, 2003).

Whilst it was evident that reflection formed part of the clinical practice of the participants, this was constrained by the pressures of a busy caseload. As will be discussed in relation to the Facilitatory factors, the participants valued the system of mentoring and supervision available within their work place. Although this afforded them the opportunity to discuss patient cases and learn from others, the extent to which this process embraces the insightful awareness of RCC is questionable.

The participants’ value and respect for their patients as individuals is closely linked with getting to know the patient (Section 5.4.3). Together they could be considered to facilitate the next stage in the process of selling the idea of self-management. In the
next section the strategies relating to exploring goals are discussed. This is related decision-making and participation with a particular emphasis on the extent to which choice is integrated into the process and to which a true partnership can be attained.

b. Exploring goals of management

The identification of treatment goals incorporating the patient’s perspective on the problem was clearly identified by the participants as key to engaging the patient in a working alliance. This premise has clear support in the literature where goals and goal-setting are viewed as essential and indispensible components of rehabilitation (Barnard, Cruice, & Playford, 2010; Levack, Taylor, Siegert, Dean, McPherson, & Weatherall, 2006; Siegert & Taylor, 2004). Whilst goal-setting is considered to improve patient management and outcomes (Baker, Marshak, Rice, & Zimmerman, 2001), a systematic review by Levack et al., (2006) found inconsistent results on its effectiveness, due in part to methodological issues. Whilst there was strong evidence that challenging goals can improve immediate performance, the evidence surrounding its effect on improving outcomes was weak and there was only limited support for its influence on adherence. Only two of the studies in the review focused on musculoskeletal disorders and these provided contrasting results in terms of its influence on patient outcomes. These studies are now discussed.

Artnetz, Almin, Bergstrom, Franzen, and Nilsson (2004) demonstrated that intervention group patients who were involved in a joint goal-setting forum with their physiotherapist achieved statistically superior results for a range of physical outcome measures compared to the control group. In addition they demonstrated higher ratings for quality of care. The study was conducted in a rheumatology rehabilitation unit in Sweden and the extent to which the findings can be applied to a musculoskeletal out-patient department in the UK is questionable. Treatment goals are commonly used as a motivational tool with the aim of improving compliance and in the second study, Bassett and Petrie (1999) investigated the effect of collaborative goal-setting on compliance. They randomly allocated patients into one of three goal-setting groups: collaborative, physiotherapist-mandated and no set goals. The findings indicated that the no set goals group had higher compliance percentages than the other groups, but the collaborative
group were more compliant than the physiotherapy mandated group. The patients in this study were all attending private clinics for treatment to injuries sustained as a result of accidents and the authors recognise this bias and a number of other weaknesses in the study. However, the findings do suggest that goal-setting may not be appropriate for all patients.

Whilst the review by Levack et al., (2006) does not appear to provide strong support for goal-setting in rehabilitation, it has to be considered that as a systematic review it did not consider the philosophical rationale for goal-setting to enhance “patient-centredness”, which may have been supported by other methodological approaches. This issue is recognised by the authors and supported by Gladwell (2006:35) who suggested that goal-setting is one component of a “complex healthcare intervention” and as such is not amenable to investigation using an RCT. Despite the ambivalent results of research into outcomes, there appears to be general agreement that goal-setting is important in rehabilitation, however there is little consensus as to how this process should occur (Leach, Cornwell, Fleming, & Haines, 2010). The findings of my study reflect this issue.

**c. Guidance available for goal-setting**

Stage one of the process of formulating goals, the identification of goals, has received little attention in the literature. The term “goal” encompasses both an objective and the journey towards the end point (Gladwell, 2006:35). Physiotherapists are expected to establish “realistic and achievable goals to guide their management of patients” (Baker et al., 2001:1119). Standard 2b.3 of the Health Professions Council (HPC) Standards of Proficiency for Physiotherapists, states that physiotherapists should “be able to set goals and construct specific individual and group physiotherapy programmes” (HPC, 2007). The formulation of a treatment plan is also the focus of standards seven and eight of the Chartered Society of Physiotherapy’s (CSP) core standards of practice (CSP 2005). Despite this emphasis from professional bodies, goal-setting has attracted only limited attention in the core texts in the field of musculoskeletal physiotherapy (Maitland, Hengeveld, Banks, & English, 2001; Petty, 2004, 2006). It is interesting to note that in contrast, texts focusing on pain management by therapists, have explored
this aspect in much more detail (Strong, 2002). As previously discussed, clinical reasoning has received some attention in physiotherapy (Section 5.2.3.4). Whilst the processes and strategies involved have been detailed (Edwards et al., 2004a), the way in which this information leads to the identification of specific treatment or management strategies is unclear. Indeed Atkins and Esser (2008:77) suggested that the level to which patients “should or can play” a part in the clinical reasoning process requires discussion.

d. The practice of goal-setting

In my study it was evident that the participants based their goals on the findings of the assessment. Core texts within musculoskeletal physiotherapy have recommended the use of asterisks to highlight significant findings from the assessment process (Maitland et al., 2001:28; Petty, 2004:25; , 2006:120). This is supported by the Core Standards of the CSP (2005), where the identification of subjective and objective markers, or goal lists is recommended. Such markers can be patient descriptions and examination findings that the physiotherapist “chooses to review at appropriate times”. The participants’ goals were articulated as either impairment based, or functional goals as suggested by the patient or perceived by the participant. As such they reflected restrictions at the impairment or activity levels of the World Health Organizations’ classification of disability (WHO 2002). Whilst this may be the inevitable consequence of an impairment-based assessment and hence unsurprising in musculoskeletal physiotherapy, the findings are comparable to those undertaken in a geriatric assessment unit (Leach et al., 2010) and in neurological rehabilitation settings (Playford, Dawson, Limbert, Smith, Ward, & Wells, 2000). It appears that the setting of impairment goals is common practice across different specialties within physiotherapy. This may be because they are considered as steps towards more activity orientated goals, they are easy to measure and they allow patients to see changes, thereby improving motivation and adherence (Leach et al., 2010). However it is also cautionary to note that the links between impairments, limitations in function and participation in society are not well understood (Asenlof, Denison, & Lindberg, 2004).
Whilst it was evident that the participants adopted an impairment-based approach to goal-setting, it appeared to be an individual and highly subjective process. Such subjectivity could be considered to increase the potential for inconsistencies and errors. Leach et al., (2010:159) have suggested that the way in which it occurs is often dependent upon the “style of the individual therapist” and this was confirmed in their study and in one undertaken in an out-patient physiotherapy setting by Schoeb (2009).

**e. Models of goal-setting**

Stage two of the process of formulating goals of management reflects the process of “informed shared decision-making” a term adopted by Bainbridge and Harris (2005:74). In a review of goal-setting in rehabilitation, Siegart and Taylor (2004:2) stated that it is “largely atheoretic” activity. In contrast the concept has been explored extensively within medicine. Classically four models of decision-making have been identified: paternalism; shared decision-making; the professional as agent, and informed decision-making (Table 5.13). Broadly they differ in regard to the level of patient autonomy and the respective roles and responsibilities of the doctor and patient in the decision-making process (Wirtz, Cribb, & Barber, 2006).

<table>
<thead>
<tr>
<th>Model of decision-making</th>
<th>Patient involvement</th>
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<tbody>
<tr>
<td>Paternalism</td>
<td>- Information exchange is a one way process from the professional to the patient</td>
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<tr>
<td></td>
<td>- <em>The professional assumes the dominant role in decision-making</em></td>
</tr>
<tr>
<td></td>
<td>- Patient involvement is limited to receiving information or providing consent</td>
</tr>
<tr>
<td>Professional as agent/interpretive</td>
<td>- Information exchange is a two way process</td>
</tr>
<tr>
<td></td>
<td>- <em>The professional assumes the dominant role in decision-making BUT only after determining the patient’s preferences</em></td>
</tr>
<tr>
<td>Shared decision-making</td>
<td>- Information exchange is a two way process</td>
</tr>
<tr>
<td></td>
<td>- <em>Decision-making is shared between the health professional and the patient</em></td>
</tr>
<tr>
<td>Informed decision-making</td>
<td>- Information exchange is a one way process from the health professional to the patient</td>
</tr>
<tr>
<td></td>
<td>- <em>The patient assumes the dominant role in decision-making</em></td>
</tr>
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Table 5.13: Models of decision-making in medicine (Charles, Gafni, & Whelan, 1999; Wirtz et al., 2006)
Historically, paternalism has been the most common approach to decision-making within health care reflecting a “deference to professional authority” (Charles et al., 1999:652). This was augmented by the power differential between the patient and professional. Since the 1980’s however policy changes have focused on increased patient empowerment, involvement and choice. In addition, easy access to sources of information has resulted in an increased level of medical knowledge in the lay population (Thompson, 2007). This, combined with an increased awareness of the fallibility of the medical profession and an awareness of the expertise brought to consultations by the patients themselves, has resulted in new approaches to decision-making within healthcare in which the patients assume a much greater role (Charles et al., 1999; Say et al., 2006; Thompson, 2007). The shared, informed and professional as agent models have grown out of this evolution in thinking and policy changes.

Shared decision-making is viewed as an integral part of PCC (Sandman & Munthe, 2010; Wirtz et al., 2006) and RCC (Roter, 2000). It is suggested that it characterises a position of mutuality that reflects the “strengths and resources of each participant on a relatively even footing” (Roter, 2000:6). The professional as agent model assumes that the patient communicates their values and preferences to the health care professional, who then becomes the decision maker. Gafni, Charles and Whelan (1998:352) have argued in favour of the informed decision-making model over professional as agent in terms of practical implementation. They suggested that it is easier for the doctor to transfer information to the patient, than the patient to transfer their preferences to the doctor, adding that patients’ preferences are “neither uniform nor stable”. In a critical review of models of decision-making, Wirtz et al., (2006) acknowledged that there is considerable overlap between the models and that in practice it is likely that elements are used in combination. It is also suggested that the shared model may not be a distinctive entity as it is possible to integrate a number of elements of it into the other models, whilst still retaining their key features (Sandman & Munthe, 2010).

In my study, three of the four classic models appeared to be represented in the responses of the participants. There was no evidence for the professional as agent model. A shared approach was clearly an aim for many; however this was balanced
with the recognition that in reality the scope for patient choice was limited. Sepucha and Mulley (2003) have suggested that a pre-requisite for shared decision-making is the recognition that there is a decision to be made. Charles et al., (1999:656) concurred, indicating that for a shared model to be successful, both the patient and the professional have to perceive that choices are available; “otherwise there is nothing to decide”. Karnieli-Miller and Eisikovits (2009) indicated that two or more treatment options are a basic requirement for sharing a decision. It is perhaps the perception of limited choice and the pre-conceived emphasis on functional ability that is the source of some of the tension expressed by the participants.

f. Involving the patient

In contrast to the paucity of literature relating to the identification of goals, the concept of patient involvement in the decision-making process has attracted some attention within physiotherapy; although this is relatively limited compared with other health professions (Bainbridge & Harris, 2005). Conversation analysis has proved a popular methodology for this topic. Parry (2004b) adopted this approach for the study of individual treatment sessions in stroke rehabilitation, whilst Barnard, Cruice and Playford (2010) extended this work to an interdisciplinary setting. Parry (2004b) found that goal-setting was practiced infrequently; when it did occur it was therapist-led and the patient’s involvement was limited. The key finding in the study by Barnard et al., (2010) was that patient wishes were not necessarily translated into goals, but instead modified by the team so they were achievable and appropriately worded.

Leach et al., (2010) adopted an email semi-structured interview approach to the study of patient-centred goal-setting in a geriatric assessment unit. The findings revealed three broad categories; although the patient focused approach was only adopted by one of the eight therapists (Table 5.14). Whilst the participants in the study by Leach et al., (2010) came from a variety of professional backgrounds, the findings are confirmed by a phenomenological study of physiotherapists’ experiences of patient participation in their management. Larsson, Liljedahl, and Gard (2010a) also identified three categories of participation: collaboration, guidance and expertise. The authors suggested that these reflected the different paradigms of health and disability, with collaboration reflecting the
biopsychosocial perspective and guidance and expertise reflecting the biomedical paradigm.

<table>
<thead>
<tr>
<th><strong>Goal-setting</strong></th>
<th><strong>Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist controlled</td>
<td>Goals were underpinned by the impairment based assessment with the therapist determining the goals and frequency of treatment</td>
</tr>
<tr>
<td>Therapist led</td>
<td>The therapist continued to lead the process however this was in collaboration with the patient</td>
</tr>
<tr>
<td>Patient focused</td>
<td>The patient and their family identified the goals</td>
</tr>
</tbody>
</table>

**Table 5.14: Categories of goal-setting (Leach et al., 2010)**

Using a more quantitative approach, Baker et al., (2001) found that whilst physical therapists did strive to attain patient participation, they failed to maximise the potential for involvement. Interestingly the study also highlighted a mismatch between the therapist perceptions of the extent to which they involve patients and the clinical reality. Apart from the study by Larsson et al., (2010a) which included participants from a range of specialities, the studies outlined above were not undertaken in relation to musculoskeletal physiotherapy. Nonetheless, some of their findings resonate with the findings in my study. To date the only study carried out in an out-patient physiotherapy setting confirmed a combination of a therapist-led and collaborative approach (Schoeb, 2009). However this study involved only three participants, two of whom were relatively inexperienced.

**g. Resolving issues with goal-setting**

Despite the fact that therapists are urged to make “strenuous efforts” to attain patient participation in goal-setting (Playford et al., 2000:495), it is clear from my study and the literature that professional dominance in decision-making and goal-setting is consistent across specialities within physiotherapy. Given this situation, how can, or should, this be addressed? Wirtz et al., (2006) acknowledged this dilemma. Whilst recognising the intrinsic benefit of patient involvement in decision-making, the authors question how this can be reconciled with professional involvement, given the fundamental legal and ethical differences between accountability for health professional and patients. A consequence of their answerability to a myriad of “policy communities, institutions, professional bodies
and specific and general populations”, is that inevitably health professionals are central to any account of decision-making (Wirtz et al., 2006:121). Sandman and Munthe (2010:78) have argued that shared decision-making is “not a description of reality, but an ideal that should be applied”. As a pragmatic alternative they introduce a model they term professionally driven best interest compromise (PDBIC). Here decision-making is seen as a process of strategic decision-making by the health professional, balancing elements of paternalism and patient autonomy. In this model the health professional believes they know the optimal management plan for the patient, but is committed to involving the patient (Table 5.15).

### Requirements of the health professional

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health professional is committed to act in the best interests of the patient</td>
<td></td>
</tr>
<tr>
<td>The health professional is open in terms of their agenda</td>
<td></td>
</tr>
<tr>
<td>The health professional wishes to ensure adherence to the decision and will be committed to a treatment the patient finds acceptable</td>
<td></td>
</tr>
<tr>
<td>The health professional is motivated to compromise, within certain limitations, if the patient is not willing to accept what is viewed as in their best interest</td>
<td></td>
</tr>
</tbody>
</table>

**Table 5.15: Professionally driven best interest compromise model of shared decision-making (Sandman & Munthe, 2010)**

To this end they try to "persuade" the patient to accept the decision, whilst being sensitive to the patient’s perspective. The authors recognised that the model may be construed as being disrespectful to the patient. However they counter this by indicating that the health professional should be open and honest regarding their position, allowing the patient to determine whether to compromise with their decision. The theoretical model of PDBIC does appear to reflect the findings in this study. Unfortunately the description of it by Sandman and Munthe (2010) leaves a lot of questions unanswered and it does not appear in any other accounts which could potentially serve to clarify some of the concepts. In particular the process by which the health professional involves the patient is unclear.

**h. The patient’s perspective**

The perception of some of the participants that questioned patients’ desire to be involved in decision-making has received some support in the literature. Despite the
move towards increasing patient involvement in decision-making, Elwyn et al., (1999), suggest that it may not always be the most appropriate model and patient characteristics and the context should be additional considerations. An early review of the literature in relation to patient participation in medical decision-making (Guadagnoli and Ward 1998), revealed many methodological limitations which made it difficult to draw conclusions. Overall the review revealed that patients wish to be informed of options and involved in decisions. An attempt to classify patients according to their preference for involvement in decision-making was made by Rowland and Holland (Table 5.16) (1989, cited in Guadagnoli & Ward, 1998). They proposed that physicians modify their style to take into account the patients preferences. However this approach does not incorporate any element of discussion and assumes that patient preferences are fixed entities.

<table>
<thead>
<tr>
<th>Type</th>
<th>Response</th>
<th>Physician style</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>You decide for me</td>
<td>Paternalistic</td>
</tr>
<tr>
<td>ii</td>
<td>I demand you do procedure X</td>
<td></td>
</tr>
<tr>
<td>iii</td>
<td>I cannot decide</td>
<td></td>
</tr>
<tr>
<td>iv</td>
<td>Given the options, your recommendations and my preferences, I choose treatment X</td>
<td>Informative</td>
</tr>
</tbody>
</table>

Table 5.16: Categorising patients preferences (Rowland and Holland 1989, cited in Guadagnoli & Ward, 1998)

More recently, a large scale qualitative study involving 208 participants revealed five broad levels of expressed desire for involvement in health consultations (Thompson, 2007). From this information a taxonomy was developed in which these levels were aligned with existing theories of professionally determined levels of involvement (Table 5.17). The patient determined column represents the extent to which the patient wishes to be involved in decision-making. The spectrum ranges from non-involvement, where patients either place their trust implicitly in the health professional or do not possess the knowledge or self-responsibility to embrace the concept of involvement, to autonomous decision-making which attracted relatively little support. The co-determined column symbolises the position where the patient wishes to participate in the sharing or discussion of decisions, to exercise an informed choice in partnership with the health
professional. However, this can only be achieved if the health professional is willing to accommodate their perspective, share power and engage in communication with the patient. Despite a desire for sharing, patients may still prefer the final decision to be taken by the health professional (professional as agent). In a population-based study in the United States, it was found that whilst the majority of the respondents (96%) wished to be offered choice and to be asked their opinions by their doctor, when it came to the final decision, 52% preferred to leave this to the doctor (Levinson, Kao, Kuby, & Thisted, 2004). More specifically to physiotherapy, Cooper et al., (2008) found that the majority of patients wanted the physiotherapist to take the lead in the decision-making process, as long as this was accompanied by clear explanations.

<table>
<thead>
<tr>
<th>Patient desired level</th>
<th>Patient-determined (Involvement)</th>
<th>Co-determined (Participation)</th>
<th>Professional-determined</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Autonomous decision-making</td>
<td></td>
<td>Informed decision-making</td>
</tr>
<tr>
<td>3</td>
<td>Shared decision-making</td>
<td>Professional as agent</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Information giving</td>
<td>Dialogue</td>
<td>Consultation</td>
</tr>
<tr>
<td>1</td>
<td>Information seeking/receptive</td>
<td></td>
<td>Information giving</td>
</tr>
<tr>
<td>0</td>
<td>Non involved</td>
<td></td>
<td>Exclusion</td>
</tr>
</tbody>
</table>

Table 5.17: Levels of patient involvement in decision-making (Thompson, 2007)

It has been suggested that the preference for involvement in decision-making may be a process which develops over time (Say et al., 2006). Patients may wish to be involved at different levels at different times depending, for example, on the seriousness or chronicity of their condition (Thompson, 2007). Characteristics such as educational status, advancing age, gender, health status, ethnic origin, experience of illness and medical care have all been identified as “effect modifiers”, although no single variable is predictive of desire for involvement (Elwyn et al., 1999; Levinson et al., 2004; Say et al., 2006). In addition, the social meaning of illness to the patient and their attitude towards decision-making may also influence their preferences for involvement (Say et al., 2006). The findings of all these studies indicate that patient involvement is a “complex, multifaceted and dynamic concept” (Thompson, 2007:1308). Whilst a considerable
proportion of patients endorse greater involvement, preferences vary widely and the health professional has to be sensitive to the individual patient. It was evident from my study that some of the participants held quite strong views regarding their professional role and this was translated into a more paternalistic approach to decision-making. Two comments perhaps sum up this issue. Guadagnoli and Ward (1998:329) have suggested that whilst not all patients wish to assume complete control over their healthcare, it is important that their “concerns, desires, and values be incorporated into decisions about their care”. Kravitz and Melnikow (Kravitz & Melnikow, 2001:585) concurred by stating “most patients want to see the road map, including alternative routes, even if they don’t want to take over the wheel”.

Selling the idea has been identified as being at the centre of the core category and has been explored in detail. It was evident however that the process of engaging the patient was not always straightforward. A number of common issues arose and the next section explores these issues and the strategies adopted by the participants to try and resolve them.

5.5.4 Issues with attaining patient engagement

The main issues are depicted in Figure 5.15, and these are now discussed in turn. It should be stressed that all the issues were discussed in relation to the management of chronic LBP as the participants did not treat many patients with acute pain. In addition the management of this problem was viewed as relatively straightforward.

i. Ascertaining patient determined goals

Whilst the participants strived to adopt a shared model of goal-setting utilising goals identified by their patients, this was often problematic. It was perceived that patients’ demonstrated considerable variation in their awareness of this issue. It was evident that the participants put a lot of effort into this process:

You have to kind of tease the problems out, prompt them, maybe it is things around the house or things to do with work and sometimes you end up stumbling across things that they haven’t thought of that are actually a problem (PT5: 6: 217)
Where this continued to prove problematic, they often took the lead utilising information from the subjective questioning:

*Just get as much information about their lifestyle as possible and their social history and then you can take an educated guess as to what they need to get back to* (PT9: 7: 315).

*So I just try and pick things that they maybe said in their subjective, their hobbies, their interests, and try and say “what about..” and probably then become a bit suggestive about things* (PT7: 5: 190)

Continuing issues could result in the participants working towards their own goals:

*There are some people that you just can’t and I won’t pursue it and maybe that is when my goal will become more physiological or physio based* (PT6:9: 397)

**ii. Focusing on function**

In contrast to the focus on functional ability by the participants, it was evident that for many patients pain relief was their goal:

*They will say “I want to be pain free”........I often feel that “OK, yes of course that is going to be your goal to be pain free, but you know so I am not going to be able to achieve that with a lot of people”* (PT6: 3: 117)
Consistent with their strategies for interpreting the problem (Section 5.2.3.i), the participants used their subjective examination to determine functional limitations and shift the patient’s focus from pain to function:

*I think quite often they come in with that problem (pain) and then we probably turn it around to make it something we can measure a little better, whether it be like a functional task because their pain is better they can then do that*  

(PT5: 6: 231)

It was evident however that this was the source of additional tension:

*We’re trying to be patient-centred, but ultimately we can’t always achieve what they want and therefore you almost feel like you manipulate them to fit what you can offer*  

(PT6: 3: 123)

iii. Managing expectations

Closely linked with managing chronic pain were issues associated with the patients’ perception of their role in their management. As previously discussed, the participants’ perceived that some patients wish to adopt a passive role in their management particularly in respect of the use of manual therapy (Section 5.3.2). Many of the strategies discussed in reconciling perspectives were focused on modifying and influencing this expectation. It was evident however that this could persist and affect the participant’s ability to engage the patient in their management:

*They just want that hands-on approach, that one to one, and it doesn’t matter what you try and do, they’re just not going to be happy if they’re not getting that one on one approach*  

(PT9: 3: 112)

The extent to which the patients’ expectations were met could be regarded as dependent on the treating therapist. This was particularly evident when it came to the use of manual therapy (Table 5.18). It was apparent that for some participants manual therapy was inconsistent with their role. In contrast, others integrated it to a greater or lesser degree into their overall management. Concern was expressed regarding the consequences of using passive modalities. This ranged from an issue of potential dependency to encouragement of passivity:

*I try and not be too hands on with them otherwise they get a bit dependent on it*  

(PT7: 2: 50)
It’s like negative reinforcement, you’re just encouraging that and I think that’s counterproductive  

<table>
<thead>
<tr>
<th>Judicious use</th>
<th>Integration</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>I might do a bit of hands-on with the patient, but I try and be very clear with them that this is just a short bit to kick start them to then managing (PT1: 2: 53)</td>
<td>If I pick up something I will treat it more manually you know, always incorporate it with exercises and stuff for them to do at home (PT6: 2: 98)</td>
<td>My approach I’d say is more “hands off” as a therapist (PT9: 2: 81)</td>
</tr>
<tr>
<td>Our aim here is to do some exercises, we might do a little manual therapy to get you going, but the bottom line is exercise (PT2: 9: 343)</td>
<td></td>
<td>I think I probably approach every patient that I ever treat with the idea that I do as little as I possibly can “hands on” (PT4: 1: 34)</td>
</tr>
</tbody>
</table>

Table 5.18: Participants’ views regarding the use of manual techniques

iv. Managing discrepancies

Where there were discrepancies between the views of the patient and the participants, a number of strategies were adopted to reconcile these differences. These included explanation, negotiation and persuasion:

*If I can reason it through and think a certain technique or treatment idea is going to help, then I will try and reason it through with them and explain how I think it is going to help*  

(PT5: 5: 198)

‘OK, well why don’t we come to a compromise and we will do that for two sessions. If you are no better after two sessions then why don’t we try something I suggest?’ (PT1: 3: 106)

*Try and persuade them that they think it’s a good idea to exercise and improve their posture*  

(PT8: 3: 89)

However it was recognised by the participants that they tend to lead this process, usually by talking the patients round:
It is not because you are denying them any treatment, but it is just trying to get them around to your way of thinking not... because it is more realistic, because we know with evidence and experience and so on that this is probably going to work for them or giving them the best management long term  

(PT1: 4: 158)

We discuss it between ourselves but it might be slightly led by me down the pathway  

(PT2: 4: 147)

v. Managing non-engagement

It was evident that the participants strived to engage the patients through verbal encouragement:

Sometimes you have to work at it a little bit more and you have to discuss with them, you have to really work and push them into trying at least “so, look give it a go and a whirl and see how it goes”  

(PT2: 9: 348)

In the face of persistent non-engagement however a variety of strategies were adopted (Table 5.19). These included confronting the patient or terminating the treatment which appeared to be linked with the choice of the patient. Interestingly another strategy was to use the allocation of six treatment sessions as a means to avoid the first two strategies. In the case of participant four this involved “going through the motions” of treating the patient in the knowledge that the patient would not improve. For participant seven it meant a “get out clause”.

A staged approach was also evident. Initially the participants explored the reasons for the lack of engagement in order to facilitate patient involvement. If this did not produce the desired result, it appeared that their approach became more assertive. In particular the participants emphasised the importance of the patient’s responsibility in fulfilling their side of the bargain:

After the second time I then come on quite strong with the patient and say “look I don’t want to waste your time, you don’t want to waste my time you know”  

(PT9: 4: 152)

If you want to take ownership of your condition and you want to get the most out of it then you now you need to take on board everything I am saying. Do the exercises and you’ll see the benefits so again they have the choice to do it, they have the choice not to. I think if you give them everything they need to, then it’s up to them really whether they take it on board or not  

(PT7: 14: 537)
Table 5.19 Strategies for addressing persistent non-engagement

Perhaps reflecting its complexity, it is evident that the core category is associated with more issues than the other sub-categories. These are now discussed with reference to the relevant literature.

vi. **Concept building in relation to the Issues with attaining patient engagement**

Three factors appear to be influential in the issues with attaining patient engagement:

- acceptance of pain by the patient;
- the meaning of goals to the patient;
- the interactional strategies adopted by the physiotherapist.

These are now discussed in relation to the literature.

a. **Acceptance of pain by the patient**

The first factor that links all the issues relates to acceptance by the patient that they have a chronic problem for which there is no curative treatment. Gladwell (2006:38) has suggested that goal-setting can commence “once there is agreement between the patient and the clinician that it is an appropriate area to explore”. In the PCCM, it is considered that goals and priorities of treatment can be explored once the doctor and patient are in agreement about the patient’s problem (Belle Brown et al., 2003c). It is suggested that an important step in adapting to the presence of a chronic problem,
the patient’s belief that they can control their symptoms (Main et al., 2010). McCracken (1998) found that greater acceptance of pain (as measured by a pain acceptance questionnaire) was associated with improved adjustment to pain across a range of pain-related variables. This was confirmed by May (2007) who found that a history of back pain assisted the participants in his study to tolerate their problem, cease to expect a cure and accept a self-management approach. Whilst it is acknowledged that the biomedical model, so entrenched in Western cultures, contributes to the belief in a cure, McCracken (1998) has argued that patients need to be informed about the reality of their situation as a first step to acceptance. Leach et al., (2010) also found frequent discrepancies between the goals of the patient and therapist and suggested that patients may need to be educated with regard to what is realistic, given their position on the course of recovery.

In my study it is evident that the participants were faced with many patients who had not been informed that complete symptom resolution was not possible. Frequently, this left the participants struggling to ascertain relevant goals in the face of unrealistic expectations. A number of factors may contribute to this situation. Gladwell (2006:38) has argued that it may be exacerbated by a symptom-based assessment which can lead patients to assume that the physiotherapist may only be interested in symptom resolution. In addition, the lack of cohesion amongst the various services and healthcare professionals encountered by patients with LBP may play a part in their ongoing attempts to find a resolution to their problem. Whilst it was evident that an honest explanation of the patient’s problems was appreciated by patients (Section 5.3.6), this may be insufficient. It has been suggested that physiotherapists can assist patients move from a position of solution-seeking to a more self-management approach through the use of “motivational interviewing” (Gladwell, 2006:39). The clinical applicability of this approach is discussed in Chapter 6.

Closely linked to acceptance of pain and the lack of a cure for their problem is the patient’s belief system. The congruence between patient and therapist beliefs has been identified in this study as being influential in attaining patient engagement (Section
5.3.2). In their review of the influence of beliefs and expectations on recovery from back pain, Main et al., (2010) highlighted the pivotal role of self-efficacy beliefs. Self-efficacy theory developed from the work of Bandura (1977) and is one of the theories that has been applied most successfully to changing physical activity behaviour (Marcus & Forsyth, 2003). There is considerable evidence that self-efficacy is an important mediator of disability related to pain. In a prospective study of chronic pain patients attending a pain clinic, Ashari and Nicholas (2001) demonstrated that self-efficacy beliefs are an important determinant of pain behaviours and pain-related disability. In a study of patients with both sub-acute and chronic pain, Denison Asenlof and Lindberg (2004) also found that self-efficacy was the most important determinant of disability. The authors suggested that a systematic assessment of self-efficacy and fear avoidance regarding activities of daily living may be more appropriate for management than information regarding pain duration and intensity. The findings and recommendations of this study are supported by Woby, Roach, Urmston and Watson (2007a) who found that lower functional self-efficacy was a strong predictor of pain intensity and disability in patients with chronic LBP. Additionally it was demonstrated that self-efficacy mediates the association between pain related fear and disability (Woby, Urmston, & Watson, 2007b). This suggests that high levels of pain-related fear may not result in an increase in pain intensity when functional self-efficacy is high. Whilst confirming the importance of assessing self-efficacy, it is also suggested that physiotherapists may lack the skills to implement cognitive interventions and additional training may be required (Woby et al., 2007a). The practical application of this for musculoskeletal physiotherapy practice is explored in the Chapter six.

b. The meaning of goals to the patient
Goals can be considered as “objects” and as such their meaning to the patient and health professional may vary (Blumer, 1969:69). Consequently the way the patient is prepared to set or act towards goals will depend on the meaning they attach to the goals. It is therefore important that health professionals get to know the patient as an individual so they can be involved in their decision-making (Zoffman, Harder, & Kirkevold, 2008). Supporting the individuality of the process, Siegert and Taylor (2004:3)
noted that the process of goal-setting “implies a set of assumptions or a world view that may not necessarily be shared by all clients or patients”. They have suggested that the concept of setting objectives, with progression towards them in a series of stages, reflects the culture of the health professionals. This may not be reflected in the patients' understanding of the process. It has also been suggested that health professionals are reluctant to obtain an insight into the patients' perspective. This may be attributed to tensions generated by different viewpoints or difficult issues (Zoffman et al., 2008). It may also reflect the professionally driven best interest compromise model of decision-making in which the participants appear to be engaged (section 5.4.3.4) (Sandman & Munthe, 2010). As discussed this involves a process of strategic action in which the physiotherapist dominates the goal-setting agenda.

c. **Interactional strategies utilised by physiotherapists**

The participants in the study identified goal-setting as integral to their ability to engaging the patient in a working alliance. It was evident however that this process was not always a simple one. This finding is confirmed by a number of studies that concluded that the process of goal-setting is complex, challenging, time-consuming and requires considerable effort and skills on behalf of the therapist (Barnard et al., 2010; Parry, 2004b; Schoeb, 2009). The communication strategies adopted by health professionals appear to be an important factor in the success of this process. Interestingly Wirtz et al., (2006) suggested that existing theoretical models of decision-making fail to address the communication process that occur between the health professional and patient during the process of decision-making. In the study the participants used the terms *explanation*, *persuasion* and *negotiation* to describe their communication strategies for patient engagement. Explanation appeared to be the first step and as discussed in reconciling perspectives this was used extensively by the participants. Persuasion and negotiation appeared to be introduced in the presence of a lack of agreement.

A study of the strategies adopted by physicians in shared decision-making, illustrated that the participants adopted a number of persuasive strategies to achieve adherence to the treatment they recommended for the patient (Karnieli-Miller & Eisikovits, 2009) (Table 5.20). The minimal level of patient involvement, coupled with the tendency for the
doctors to coerce the patients through the use of their power and status, led the authors to describe the encounter as a “persuasion mission” (Karnieli-Miller & Eisikovits, 2009:7). Whilst the client group and context in this study (newly diagnosed adolescents with chronic illness) were quite different to my study, there are still some similarities in the professional dominance of the strategies, particularly in the use of “we” and the “illusory power to decide”.

<table>
<thead>
<tr>
<th>Marketing the treatment</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dramatising the evil</td>
<td>Emphasising the seriousness of the condition</td>
</tr>
<tr>
<td>Deterring versus encouraging</td>
<td>Using the stories of other patients to convince the patient</td>
</tr>
<tr>
<td>The use of “we”</td>
<td>Using plurals to enhance the credibility of the recommended intervention</td>
</tr>
<tr>
<td>The illusory power to decide</td>
<td>Creating the illusion of choice but within clear boundaries</td>
</tr>
<tr>
<td>Avoiding the offer of treatment alternatives</td>
<td>Presenting a single treatment option when others are available</td>
</tr>
<tr>
<td>Emphasising the benefits of treatment and frightening patients about non-compliance</td>
<td>Emphasising the long term implications of non-compliance when there is a clear discrepancy between preferences</td>
</tr>
<tr>
<td>Emphasising the ability of the intervention to control side effects</td>
<td>Mainly in relation to drug intervention</td>
</tr>
<tr>
<td>From mild to serious medicine</td>
<td>Presenting the chosen treatment as a gradual process</td>
</tr>
</tbody>
</table>

Table 5.20: Persuasive strategies adopted by physicians (Karnieli-Miller & Eisikovits, 2009)

Klaber Moffett et al., (2006:115) have suggested that in the face of patients’ unrealistic expectations, negotiation of treatment goals may be necessary. They suggest that this is a skill involving a careful selection of words, to elicit expectations, to form a basis for a discussion of goals. However Sandman and Munthe (2010) have argued against the use of the term “negotiation” in decision-making, suggesting that it implies business model of bargaining that is incompatible with healthcare. Instead they suggested that the process is one of “deliberation” whereby both participants work together to find a mutually
acceptable agreement. However the operationalisation of this process in the face of discrepancies is not detailed.

Little work has been undertaken within physiotherapy to explore the interactional strategies adopted by physiotherapists. In an analysis of communication during goal-setting in a stroke rehabilitation unit, Parry (2004b) found that most of the participants supplied the problems to which the subsequent goals were set. In a detailed analysis of the only interaction in which the therapist encouraged the patient to determine the goals, a number of issues arose. It was evident that the therapist increasingly constrained the problems introduced by the patient, to eventually devise goals that are amenable to physiotherapy. Parry (2004b:679) concluded that goal-setting is a “complex interactional activity” that requires the development of further knowledge and professional guidance. The implications of this for physiotherapy practice are discussed in Chapter six.

A number of additional factors, both facilitatory and constraining, were identified which profoundly influenced the ability of the participants to engage their patients in a shared partnership. In light of the number of these factors, they are considered separately.

**5.5.5 Facilitatory factors**

It is in relation to this aspect of the core category that the relationship and mutual dependency of the sub-categories becomes most evident (Figure 5.16). The process of *interpreting the problem* enabled the participants to obtain an in-depth understanding of the patient. Through *reconciling perspectives* the patient’s knowledge and understanding of their problem, and the role of physiotherapy in managing it, was enhanced. Finally the *therapeutic alliance* facilitated the collaboration between the patient and physiotherapist. In addition to the facilitatory influence of the sub-categories, three additional factors were identified as influential. These included:

- effective communication skills:
- the value of experience:
- the system for mentoring and supervision within the physiotherapy department.
**Effective communication skills** could be considered as integral to the whole process of *engaging the patient* and have been discussed in relation to each of the sub-categories. It was evident that the participants were aware of the influence of their communication with patients. References to communication pervaded their responses to the interview questions, demonstrating their ability to deliver information, communicate easily and openly and listen to the responses. It was evident that the participants were sensitive to the patients and attended to both verbal and non-verbal cues. Table 5.20 illustrates some examples of the numerous responses relating to communication skills throughout the sub and core categories.

Figure 5.16: The interrelationship of the core and sub-categories (IP=Interpreting the problem; RP=Reconciling perspectives; DA=Developing an alliance; EP=Engaging the patient)
Table 5.2: Examples of the communication skills of the participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Illustrative examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreting the problem</td>
<td>I think you have got to do it in a very tactful way and it depends on the patient’s personality (PT1: 9: 372)</td>
</tr>
<tr>
<td>Reconciling perspectives</td>
<td>It is not always what information you give them, it’s how you put that across as well and how important you make it sound to the patient (PT5: 11: 439)</td>
</tr>
<tr>
<td>Developing an alliance</td>
<td>You might have to be a different person for different types of patients (PT8: 13: 449)</td>
</tr>
<tr>
<td>Engaging the patient</td>
<td>You can only say “well my approach is this, what do you think about that? Are you prepared to give it a try?” (PT8: 8: 274)</td>
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By using “we” instead of “I”, some participants associated effective communication skills with being a physiotherapist:

*I think (listening) it’s a valuable skill we have and I think they (patients) value it (PT7: 11:424)*

Despite the problems some of the participants faced in ascertaining goals, involving the patient and persistent non-engagement, this was not considered in relation to their communication skills.

*The value of experience* was identified as a key factor in all the sub-categories and it was evident that it profoundly influenced the ability of the participants to engage their patients in a working alliance. They indicated that as they developed professionally, their focus shifted from a skill-based to a more holistic approach into which they integrated postgraduate education, experience and latest evidence and guidelines. As a junior physiotherapist they recognised that the focus was very much on treatment modalities and enhancing clinical skills. Through patient mileage came the realisation that this was only one aspect of patient management, consequently they moved to what participant one termed “the next level of experience” (PT1: 11: 456). This was summed up by participant two:

*Because you learn all your skills and you are quite happy with it and then you are thinking well for some of them it doesn’t really work and therefore what else is there and you start looking down other avenues. At the beginning you just want to be the best you can and cure everyone and then it doesn’t work like that (PT2: 12: 476)*
Professional experience through patient mileage was linked with improved confidence:

I think a lot of that is your own experiences and how confident you are in your assessment and handling skills. (PT6: 3: 93)

In contrast to the other participants, participant seven had only moved into the outpatient department of the Trust a few months prior to the study. She appeared less confident than the other participants:

You do question yourself, have I done everything for the patient and have I done all the tests possible, am I doing the right things for them? (PT7: 6: 226)

Experience was also identified as a key factor in enhancing the participant’s ability to deal with more complex issues and it was recognised that this was a particular issue for junior therapists. Whilst learning to deal with such issues could be facilitated through supervision and mentorship, again patient mileage was integral to this development:

Had I seen her as a junior it would have been an absolute nightmare. (PT2: 7: 264)

We tell all our students that as you see more patients, as they have more contact with the general public, you just grow and learn. (PT3: 6: 249)

It was evident that for some participants, experience was also linked to emotional maturity, enabling them to be more flexible and responsive in their approach:

I think I went through a stage where I would stick to my guns and I would do the treatment that I thought was most appropriate and then, I do find nowadays I’ve learnt that in actual fact, even if you think that’s the right treatment for them if they don’t think it is, they won’t get better with it. So sometimes I will say “what do you think will help you?” you know and unless it is really contraindicated I sometimes do it. (PT6: 7: 334)

The participants’ work place offered a robust system of mentoring and supervision on a formal and informal basis. This was universally recognised and valued by the participants:

There are always opportunities to kind of block out time and speak to people or get someone in for a second opinion. (PT5: 8: 307)

I have my supervisor who I can talk to; I have peers I can talk to. If there is anything, I will just do my blurb and that is fine. It is nothing formal, but there is a lot of informal things that do go on. (PT1:10: 410)
The support for more junior members of staff was evident, particularly when it came to managing more complex cases:

> If they are having a real issue with a patient then there is lots of us around, the senior staff, experienced seniors who can say “I will come and give you a hand”

*(PT2: 7: 272)*

Despite this, some concern was expressed that this was insufficient and that junior staff may only seek out assistance when confronted with a more difficult situation. Additional measures including observation and shadowing were suggested as strategies that would assist junior staff.

> I don’t think we encourage it enough though. I don’t think we encourage them to come forward; it is only if they have got a problem with the patient

*(PT1: 11: 435)*

The most junior of the participants appeared to echo this and suggested that time spent with more experienced colleagues, discussing their approach to various patient presentations, would be worthwhile:

> I think just getting together in a room and just talking about everything that everyone does differently

*(PT7: 17: 632)*

i. **Concept building in relation to the facilitatory factors**

The literature supports skilful communication as vital for effective patient management and particularly for encouraging self-management (Klaber Moffett et al., 2006). Although well developed communication skills were not delineated as specific components of the medical models of PCC (Belle Brown et al., 2003a; Mead & Bower, 2000), it is evident that they play an integral role leading Bensing, Verhaak, Van Dulmen and Visser (2000:1) to view communication as “the royal pathway to patient-centred medicine”.

Whilst the majority of the literature on communication skills relates to nursing and medicine, in recent years some work has been focused on physiotherapy. A systematic review by Jeffels and Foster (2003) concluded that the communication style of the physiotherapist can influence patient’s perceptions of pain, both positively and negatively. They suggested that a patient’s pain experience can be reduced by the
alteration of unhelpful beliefs and that physiotherapists are ideally placed to do this through the provision of information and education. This lends support to the importance placed by the participants on conveying information to engage the patient in a working alliance.

Cooper et al., (2008) and Kidd et al., (2010) developed their models of patient-centredness in physiotherapy from the perspective of the patient. Communication emerged as a separate dimension in the former and part of a communicative relationship in the latter. The constituents of “good communication” identified by the patients in both studies were broadly similar (Table 5.21) and appear to reflect the responses of the participants in this study. Studies of patient satisfaction with physiotherapy confirm the importance of effective communication (Hills & Kitchen, 2007b; May, 2001).

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<tbody>
<tr>
<td>Patients involved in the process</td>
<td>Two way transfer of information</td>
</tr>
<tr>
<td>Listening, understanding and getting to know the patient</td>
<td>Good listening skills</td>
</tr>
<tr>
<td>Taking time over explanations Using appropriate terminology</td>
<td>Paraphrasing and explaining</td>
</tr>
<tr>
<td></td>
<td>Reassurance about pain</td>
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</tbody>
</table>

Table 5.22: Components of “good communication” in studies of patient-centredness in physiotherapy (Cooper et al., 2008; Kidd et al., 2010)

The participants did not identify any specific issues with their communication skills and implied that this may be due in part to their professional education and personality. However it is suggested that healthcare providers may need to improve their skills in this area (Goldingay, 2006b:55). Recent studies appear to support this contention. Gulbrandsen et al., (2010) demonstrated that the quality of communication by health care professionals, including physiotherapists, was poorer across a range of communication behaviours, including empathy, for patients with chronic back pain. Zoffman et al., (2008) found that approaches to problem solving were mostly general, rather than individualised, professionally dominated and focused on the disease rather
than the affect of it on a patient’s life. A number of factors may contribute to this situation. Reynolds (2004a:19) has suggested that the traditional biomedical view of illness encourages health professionals to attend only to information that relates to the diagnosis of the patient’s presenting problem. The structure of the initial assessment with its emphasis on history taking and physical examination has been identified as promoting an unhelpful communication style, albeit unintentionally (Goldingay, 2006b:58).

It may be that the participants were simply unaware of the influence of their conceptualisation of LBP and professional remit on their communication with patients. Petitpas and Cornelius (2004:68) have suggested that physiotherapists need to be willing to look critically at their own communication style, to enhance their listening and counselling skills. To this end they recommended training and practice, coupled with self-awareness and an appreciation of the patient-therapist relationship. Goldinghay (2006b:55) suggested that musculoskeletal physiotherapists may question the need for training in communication skills, as they may perceive that it evolves naturally through experience. Whilst this may appear controversial, in my own University predominantly skill-based courses are oversubscribed, whilst those focusing on clinical reasoning incorporating enhanced communication skills struggle to be viable. A systematic review of the effects of interventions to enhance communication performance in allied health professionals (AHPs) did not reveal any studies relating to qualified physiotherapists (Parry, 2008). Evidence from other disciplines indicates that training is most effective when it is based on a thorough understanding of the communication practices in discrete clinical areas. Parry (2008) suggested that this presents a considerable barrier for AHPs as there is currently limited evidence as what actually constitutes their communication practices. The need for evidence from direct observation is highlighted as key to underpinning the design of training programmes and although Parry (2008) indicated that this has started in physiotherapy, the studies cited are dated or do not relate to musculoskeletal physiotherapy. On the basis of the results from my study, it is evident that there is a pressing need for research into communication in musculoskeletal physiotherapy practice.
The value of patient mileage and experience reflects the findings of Daykin and Richardson (2004) who linked experience with confidence and self-efficacy. Ewing and Smith (2001:25) concurred with this premise suggesting that professional practice develops in stages, the length of which will vary between individual practitioners (Table 5.24). Movement through the stages is associated with increasing levels of self-efficacy. Consequently higher levels of self-efficacy are associated with greater experience. This model of professional growth certainly reflects the responses of the participants who recognised that their initial focus tended to be on skills, and the experience of the most junior participant who was the least confident in her ability.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Concerns</th>
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<tbody>
<tr>
<td>Self-focused</td>
<td>Concerns regarding ability to do the job</td>
</tr>
<tr>
<td>survival</td>
<td></td>
</tr>
<tr>
<td>Self-centred</td>
<td>Concerns about competency in skills and how these can be improved</td>
</tr>
<tr>
<td>Other-centred</td>
<td>Concerns regarding the impact of practice on the patient</td>
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Table 5.23: Stages of professional growth (Ewing & Smith, 2001)

Clinical experience is linked with the development of professional craft knowledge, one of three forms of practice knowledge (Titchen & McGinley, 2004:109). The use of professional craft knowledge enables health care professionals to integrate and contextualise information from a variety of sources to enhance their understanding of an individual patient's problem (Higgs et al., 2004:189; Ladyshewsky & Jones, 2008:434). Such personalised care has been identified as central to the practice of “expert” practitioners (Resnik & Jensen, 2003). Reflective practice is closely associated with the development of professional craft knowledge (Smith, 2001a:176). This was evident in the responses of the participants and identified as key to facilitating patient engagement.

Experience is recognised as playing a key role in human action. Whilst action is seen as taking place in the present, information from past experiences, other situations and decisions are all acknowledged as being social objects which are used to define the present situation and guide subsequent actions (Charon, 2004:130). Although the benefit of experience was clearly recognised by the participants, it appears that this may
not necessarily be related to years of experience. Thomson, Hassenkamp and Mansbridge (1996) found mixed results in their study of empathy and clinical experience. Whilst qualified physiotherapists were found to be more empathetic than students, junior physiotherapists were found to be more empathetic than more senior grades. In the study of expert practice by Resnik and Jensen (2003) the participants classified as “expert” on the basis of their patient outcomes, were not necessarily the ones qualified for the longest. It may be that it is not necessarily longevity of practice, but the extent to which therapists have reflected on and learnt from their experience, that is key to professional development.

The value of a supportive environment was viewed by the participants as important for engaging their patients. Senior staff could discuss complex cases with peers, and junior physiotherapists benefitted from clinical supervision. Peer collaboration, support and mentorship have been identified as influential in enhancing clinical reasoning and learning (Ajajwi & Higgs, 2008:334). It is suggested that knowledge is “socially and culturally constructed” and that a profession can be regarded as a “community of practice” with its own distinct culture (Abrandt Dahlgren et al., 2004:71). Becoming a professional is therefore an accumulation of cognitive knowledge and cultural learning. The latter comprises of a set of common values, beliefs and practices characteristic of the profession. An individual’s identity changes as a result of adopting the practices of their community. They develop a sense of belonging (Walker, 2001:24) and the community becomes their reference group (Shibutani, 1955). This was evident throughout the study. The participants frequently referred to themselves as “we” rather than “I” and indicated that their practice was influenced by senior staff.

Whilst it is recommended that opportunities for discussion should be encouraged (Ajajwi & Higgs, 2008:334) the negative implications of “professional socialisation” are acknowledged (Reynolds, 2004b:113). In my study the participants recognised their limited exposure to training for the identification and management of psychosocial issues. It is likely that this would influence their supervision and mentorship of more junior staff, propagating a predominantly biomedical approach, which may constrain their ability to fully engage their patients.
5.5.6 Constraining factors

Constraining factors was the most frequent of the early codes. It was evident throughout all the interviews that the participants felt restrained, to a greater or lesser degree, by working in the National Health Service (NHS). The bureaucracy associated with a large public service was identified as compromising the ability of the participants to fully engage their patients in a working alliance. Table 5.23 provides some examples of the numerous quotes relating to this issue. Differences in culture and language were additional factors highlighted by some of the participants (Figure 5.17).

![Diagram of constraining factors](image)

Figure 5.17: Constraining factors for engaging the patient
### Constraining factor | Examples
--- | ---
Limit to length of treatment sessions | • The time constraints on your appointments (PT8: 16: 552)
• Time obviously like I said if it’s a half hour session you’ve got a complex back you can’t always manage those expectations in that time. (PT6: 15: 710)
• I think if you know you are restricted perhaps to half an hour if you think there might be other issues bubbling under the surface, you are probably less likely to ask about them…because you haven’t really got the time to then answer them. (PT5: 13: 520)

Limit to number of treatment sessions | • We are all pushed to get patients seen within four or six sessions, so it is always going to be reducing our treatment slots (PT1: 8: 32)
• We’re quite flexible in that you can ask for more, but if the GP doesn’t want to give more, you can’t have any more (PT7: 15: 586)
• It is a problem where you have actually maybe gone down one course and feel that you need to sort of go off on another one that we are limited there (PT4: 8: 344)
• I think also with the demands on your caseload that the other is to get them in, get them out quick enough. So you try a few things, it’s not really working, quite a long term back pain, off you go with your exercises. (PT2: 10: 412)

Breaks in continuity of care | • Some doctors are very good at continuing (approving more treatment) but it is also a problem that if there is a time delay between asking and getting confirmation that it is OK, then what do you do with the patient in the meantime? (PT4: 8: 351)
• And also we have set up classes to absorb more people from the waiting list, taking away the one to one and hands-on (PT3: 9: 356)
• And I said OK I will see you in two weeks for half an hour and that is going to change the amount of progress she makes I am sure of it (PT3: 8: 339)

Bureaucracy | • Unfortunately, there is a lot of red tape and managerial stuff that inhibits us from doing those type of things (PT2: 9: 386)
• I think the cross-referencing of information within the hospital could be a lot better as well. We are always sending back referrals saying “not enough information” (PT3: 9: 376)
• Pressures on the services, you know budgets, finances and they do impact on the patient (PT9: 12: 581)
• There are still a lot of barriers for the patient, certainly with things like obtaining medical notes and scans and things like that (PT3: 5: 181)

Table 5.24: Illustrative quotes relating to constraining factors
Insufficient time was by far the greatest stress. In relation to this two issues were particularly pertinent, firstly the length of the waiting list for physiotherapy and secondly the restriction to six sessions for GP referrals. As a consequence of the former, the appointment times were reduced from an hour to half an hour and this placed the participants under considerable pressure. The opportunity for patient participation in the decision-making process was curtailed:

If you have half an hour new patient assessment...you know sometimes I feel like I’m trying to fit it in a few minutes at the end (PT6: 3: 133)

The restriction to six sessions was a source of additional pressure:

I am always much more aware of those patients I’m treating that have GP referrals than consultant ones (PT7: 16: 590)

Whilst the participants acknowledged that the facility for requesting additional treatment sessions from the patient’s general practitioner (GP) was available, this could result in a break in continuity of care. An attempt to manage waiting times involved the increasing use of classes. The participants however expressed mixed views regarding their benefits. The reduced opportunity for patient-therapist discussion was balanced with the increased opportunity for peer support and interaction. The decision to refer a patient to a class appeared to be a therapist-led process:

We always assess the patients first to decide if they are suitable for the class. I think if they are perhaps a bit more complex and there are lots of issues then they might be best kept maybe one to one (PT5: 12: 508)

Potentially, the consequences of a lack of patient participation in the decision-making process, was a termination of the working alliance:

Some patients really like it, but a lot of them don’t, and they’ll agree to go and then we’ll find that they’ll not attend (PT6: 10: 481)

Paradoxically the restriction to six sessions for GP referrals impacted upon the potential for classes to reduce the waiting list. It was evident that the decision to refer a patient to a class was often taken after some individual one-to-one sessions, leaving little time for patients to obtain the benefits from the class:

A big issue now are the classes, which are great, but referral to classes isn’t very practical logistically because we don’t have the sessions there to get people into the classes (PT9: 10: 481)
Some of the participants viewed the current situation in the NHS as one that is contrary to PCC. It was evident that they perceived that the rhetoric regarding quality of care was not matched by the reality of clinical practice:

*The difficulty with patient centred I think is that it is at odds with ... the practicality of the NHS at the moment which is get people seen and done in time and cutting down waiting lists and it is the waiting list versus quality of care. They are at opposite ends of the pole. You can't have them both; it is either one or the other. If you want to give quality care you need to give them time*  
(PT3: 2: 49)

*So all the policies, the papers, the different acts coming in for the patient quality of care, clinical governance. At the end of the day in practice it is moving away from that*  
(PT9: 12: 583)

Despite this they believed that as a department they still strived to offer a service that places the patient at the centre of their care:

*The ethos around the place that the patient is important, most important*  
(PT3: 7: 298)

*It's not actually true clinical governance. It's not really happening you know. Which is a shame but we try here*  
(PT9: 12: 584)

Finally, the Trust in which the study was based is situated on the outskirts of London and serves a multicultural population. A number of the participants identified that cultural and language differences were a barrier to successfully engaging the patient. In particular the differences in perception of pain were acknowledged as being problematic:

*I think understanding how different cultures respond to illness and the behaviour that comes around that as well, those things are really hard to manage and I don't probably feel that I always achieve such patient centred care on patients*  
(PT6:15: 706)

*And then sometimes we also have a language barrier as well, so you have got to keep everything as very general as you possibly can and not be too specific*  
(PT4: 2: 91)
i. **Concept building in relation to the constraining factors**

The constraining factors identified by the participants were predominantly related to organisational pressures. Insufficient time was clearly identified as the most significant factor and this has been a recurring issue throughout the sub-categories. The Physiotherapy Department, in which the study was conducted, allowed 30 minutes for appointments. Whilst it was acknowledged that they had more time with patients compared to other professionals, particularly doctors, completing the initial assessment in this time scale was challenging for the participants (Section 5.4.5). Within that time they had to complete the demands of the assessment process; assimilate and interpret the information obtained and convey information to the patient whilst simultaneously attempting to develop an alliance. On completion of the assessment they then had to identify the goals of management whilst striving to involve the patient. Although the participants indicated that there was a level of flexibility in their practice, it was evident that the pressure of time was a considerable constraining factor to patient engagement. Participant three was most vociferous in expressing his views regarding this issue; however it was a common topic of concern.

Resource limitations, such as waiting lists and limited treatment time, particularly within the NHS, are recognised as militating against the establishment of an effective alliance (Collins, Britten, Ruusuvuori, & Thompson, 2007:5). Inevitably, targets set at governmental level impact upon the individual therapeutic encounter (Reynolds, 2004a:23). Whilst it has been suggested that limited treatment time may compel therapists to focus on the treatment interventions, rather than listen to the concerns of their patients, this did not appear to be the issue in my study. Instead the participants felt pressurised by the responsibilities associated with their role in the time they had available. Based on anecdotal reports, I am aware that the length and number of treatment sessions is a cause of considerable concern to physiotherapists. Further reductions may potentially influence the ability of therapists to successfully engage patients in their management.

Continuity of care was identified as an additional constraining factor. It is suggested that two main factors may serve to disrupt continuity of care; policy decisions and the clinician themselves (Belle Brown et al., 2003a:123). Whilst the influence of the
former was evident in the reduction of appointment times and the use of classes, the latter was also apparent in the strategies the participants’ adopted to manage non-engagement (Section 5.5.4).

The participants did not identify any professional issues as constraining their ability to engage their patients, however Reynolds (2004a:19) suggests that the traditional biomedical view of illness encourages health professionals to attend only to information that relates to the diagnosis of the patient’s presenting problem. Lengthy professional socialisation, which on the one hand endows the health professional with highly specialised knowledge and skills, may also serve to create a distance between the two individuals in the therapeutic encounter (Reynolds, 2004b:112).

The influence of culture on physiotherapy has received some attention. Hunt (2007) suggested that the considerable influence of culture on the expectations and respective roles of the patient and health care practitioner, is often unappreciated. He argued that unless culture is considered, collaboration will be more problematic and outcomes less successful. Whilst Hunt (2007:231) indicated that a patients’ “cultural framework will influence which goals will be meaningful” for them and urged physiotherapists to strive to appreciate such values, O’Shaughnessy and Tilki (2007) have suggested that physiotherapists may feel ill-equipped when managing patients from different backgrounds. This is reflected in my study. In contrast to the literature on culture, there has been little exploration of the influence of language differences on the practice of physiotherapists. Whilst this can be linked with culture, this may not always be the case and has the potential to influence the interactions between the physiotherapist and patient.

5.5.7 A working alliance

The consequence of a successful patient engagement was that the patient was “on board” with the physiotherapist. Participant two summed it up as:

*The same hymn sheet together* (PT2: 9: 377)

It was considered that compliance was consequently improved and this had a beneficial effect on the ultimate outcome:
I think it does make a big difference because they are going to go with you in what you do and they are going to be more compliant on the whole if you have got them on board. (PT4:8: 368)

i. **Concept building in relation to the working alliance**

The vignette of the ideal therapeutic encounter outlined in the story line illustrates the results of successfully engaging the patient (Section 5.1.3). The term “working alliance” comes from the counselling literature and is generally associated with a psychoanalytical view of the relationship between patient and counsellor (Szybek et al., 2000). It represents a trusting collaborative relationship in which the patient and healthcare professional reach agreement regarding the goals of treatment and how to achieve them (Petitpas & Cornelius, 2004:57). In a review of the working alliance in relation to psychoanalysis, Bordin (1979) considered the concept as central to the process of change. As such, he suggested that it can be applied to contexts outside that of psychoanalysis and identified three central features:

- an agreement on goals;
- an assignment of tasks;
- the development of bonds (Bordin, 1979).

The commonalities between the features and the findings of my study are evident. The identification and exploration of goals was central to selling the idea of a self-management approach to LBP. Whilst this appeared to be a primarily a therapist-led process, the actions and interactions of the participants were clearly focussed on attaining agreement. The process of reconciling perspectives involved the provision of information regarding the patients’ role in their management (Section 5.3.3) and patient co-operation was both anticipated and expected. Hence successful engagement could be perceived as both the assignment and implementation of tasks. It is suggested that the agreement of goals and the assignment of tasks are “intimately linked” to the relationship between the therapist and patient (Bordin 1979 254). In my study, developing an alliance was considered to be integral to successful patient engagement.

In relation to psychoanalysis, Bordin (1979) has suggested that the outcome of treatment is directly related to the strength of the working alliance. Indeed he
indicated that the potency of the collaboration between the therapist and patient may be more important than the treatment techniques adopted by the therapist. This has received some support in the rehabilitation literature. Petitpas and Cornelius (2004:57) suggested that the quality of the working alliance has a profound influence on adherence and outcomes and without it a successful outcome is unlikely.

The working alliance can also be considered in terms of “interlinkage of action”. It is suggested that joint behaviour is formed through individuals’ fitting their lines of action to each other. Consequently a “joint action” is created. Whilst this is made up of different elements, in the case of my study the individual interpretations of the problem of back pain by the therapist and patient, the resultant behaviour is more than just the sum of the two. Instead it has “a distinctive character in its own right” (Blumer, 1969:17). Importantly it is suggested even when a joint action is a well-established one that is repeated on a regular basis, each one has to be formulated anew (Blumer, 1969:17). This means that the process of creating a working alliance is unique to the individual patient and physiotherapist.

5.5.8 Summary of the categories
This chapter started with an overview of the story line of engaging the patient. It has detailed the results of the analytical process of theoretical integration with an in-depth exploration of the three key processes adopted by the participants in order to achieve their goal. Three processes have been discussed: interpreting the problem; reconciling perspectives and developing a therapeutic alliance. These have been related to the core category of engaging the patient. Key to this process is the formulation of goals incorporating the patient’s perspective. The final stage in this chapter is to provide an explanation of the core category in theoretical terms and present the final substantive theory for my study.
5.6 A theoretical conceptualisation of patient-centred care

5.6.1 Introduction

Conceptualisation in grounded theory (GT) is considered integral to move the emerging theory from one of conceptual description to conceptual theory (Cutcliffe, 2005). As discussed in Section 4.9, the theoretical coding in this study was informed by Turner (1988). The results of the theoretical coding and conceptualisation of my theory are now described, culminating in the presentation of my substantive theory of patient-centred care (PCC). It is proposed that the process of engaging the patient is underpinned by three theoretical concepts:

- complex responsive process of relating;
- physiotherapeutic use of self;
- communicative action theory.

5.6.2 Complex Responsive Process of Relating as a foundation for patient-centred care

Complex Responsive Process of Relating (CRPR) is a theory of human interaction. It posits that social interactions consist of self-organising patterns of meaning and relating that form continuously throughout every interaction (Suchman, 2005). The theory was developed with particular reference to organisations and organisational change (Stacey & Griffin, 2005). It evolved from a desire to understand human action and life in social organisations; concepts that were inadequately explicated by the prevalent complexity theories of the time (Stanley, 2009). More recently Suchman (2005) proposed it as theoretical foundation for relationship-centred care (RCC), suggesting that it resonated with the principles of RCC. On closer analysis of CRPR I recognised its potential to also theoretically underpin my own theory. It is consistent with symbolic interactionism drawing on elements of social constructionism, sociology and complexity theory. CRPR puts the process of interaction between individuals and the processes of the human mind at the heart of all human action and of organisations.
i. **Theoretical underpinning of complex responsive process of relating**

Symbolic interactionism provides the foundation for CRPR. As such, communication is a process of gesturing and responding (Suchman, 2005). A gesture is a symbol which can take the form of facial expressions, language and posture amongst others. The responder organises their response on the basis of what the gestures mean to them, “*thus the gesture has meaning for both the person who makes it and for the person to whom it is directed*” (Blumer, 1969:9). Each response is the next gesture in the interaction, in turn giving rise to its own response (Figure 5.18). During an interaction between individuals, patterns of meaning form in this ongoing process of gesturing and responding (Suchman, 2002).

![Figure 5.18: The non-linear process of gesturing and responding (Suchman, 2005)](image)

ii. **Key elements of complex responsive process of relating**

The significance of CRPR to my conceptualisation of PCC necessitates a thorough appreciation of its key constituents.
• Humans are a social species who live in an environment of constant social interaction (Suchman, 2005), both with others and one’s self (Stanley, 2009).

• Patterns of perception and meaning evolve through a non-linear social interaction between individuals. To illustrate this, Suchman (2002) described a number of potential outcomes of a conversation. Patterns can be reinforced or perpetuated; gradually evolve; demonstrate sudden unanticipated changes; or discontinue. In other words patterns can exhibit stability or novelty (Suchman, 2005).

• The emergence of patterns is “self-organising”. This means that they are not under the control of the individuals involved rather they form unexpectedly and spontaneously. This occurs through “iterative reciprocal interaction” (Suchman, 2005:S41), an ongoing series of mutual influences.

• The development of new patterns depends on responsiveness, associative capacity and diversity. Responsiveness refers to the capacity of the individuals to be mutually aware and open to each other’s ideas. They also have to be able to form associations between the emerging themes. This associative capacity will be influenced by a number of factors including the personal characteristics of the individuals and existing patterns already established in the mind. Whilst extremely divergent perspectives or circumstances of the individuals will limit responsiveness, it is suggested that a level of diversity is required to develop new patterns of meaning (Suchman, 2002).

• In addition to the public conversations between two individuals the same iterative interactions occur in the private conversations of the mind. There is a reciprocal process whereby public conversations and private conversations both influence and are influenced by each other (Figure 5.1). Suchman (2005:S43) suggests that viewed in this way communication between individuals is a “self-organising construction and propagation of patterns of meaning within one seamless conversation comprised of both public and private elements”.

• Whilst patterns of meaning and relating arise in the interaction between individuals, they are also influenced by other factors such as previous conversations and experiences, as well as contextual factors (Suchman, 2002).
iii. **Relationship to patient-centred care**

In the sub-category of *interpreting the problem* the physiotherapists attempt to make sense of the patient’s problem through a process of questioning. In the second sub-category of *reconciling perspectives* they endeavour to merge the patient’s views and expectations with their own primarily through a process of conveying information. Such interactions reflect the “public conversations” of CRPR. The somewhat professionally dominated questioning by the physiotherapists is a gesture to which the patient’s respond. Subsequent questioning is dependent on the patient’s response and meaning for the physiotherapist is socially constructed through this process. For musculoskeletal physiotherapists this construction is shaped by numerous influences including their professional role with its own discipline specific beliefs and practices, their experience and personal preferences. In terms of managing low back pain (LBP), the physiotherapists interpret the information obtained in the assessment according to their socially constructed definitions, to formulate a management plan for the individual patient. Faced with the complexity of many patients’ problems, the information gathered is re-interpreted into factors that are amenable to physiotherapy intervention, and those that are not. The process culminates in the formulation of goals on which the management of the individual patient can be based. In this process physiotherapists attempt to reconcile the patient’s perspective with their own professionally dominated interpretation.

The focus of the “public conversation” of conveying information is on modifying expectations, attitudes and goals so patients engage in the subsequent management...
programme. Human behaviour can be considered as a stream or line of action whereby individuals change their direction in response to new situations or interactions. (Charon, 2004:117). Hence it can be considered that through the process of conveying information to the patient, the patient and physiotherapist will evaluate their decisions, change their minds and create new goals. The potential for the patient to modify their beliefs, attitudes and expectations towards their problem is apparent, as is the potential for the physiotherapist to amend their goals for the patient. As Charon (2004:118) states: “what others do in relation to us makes a difference in the decisions we make”.

The “private” conversations of the mind are reflected in the clinical reasoning adopted by physiotherapists. The process of clinical reasoning, incorporating diagnostic and narrative elements (Edwards et al., 2004a), occurs simultaneously with the public conversation, both influencing and being influenced by it. It can also be assumed that private conversations will occur in the minds of the patients. In this way the interaction between the physiotherapist and patient can be viewed not just as one of an exchange of information between two separate individuals, but rather as one from which new patterns of meaning arise. Reflecting the “interlinkage of action” of the working alliance, Suchman (2005:S43) suggests that the relationship “transcend the separateness of the individual participants” resulting in something that is more than just the sum of the individual elements.

As a theoretical framework, CRPR emphasises the evolution of self-organising patterns of meaning in social interactions. However it also recognises that the process is not random. It is constrained by certain rules which influence the potential for the emergence of new patterns (Suchman, 2002). In the interaction between a patient and physiotherapist such boundaries could be viewed in terms of the conventions of assessment, the professional remit of the physiotherapist and potential power dynamics.
5.6.3  Physiotherapeutic use of self

Whilst CRPR emphasises the process of social interaction and communication between individuals, I was concerned that it did not fully reflect the importance of the therapeutic alliance as emphasised by the participants. In attempting to explain this in theoretical terms, it became evident that the quality of the relationship between physiotherapist and patient has received little attention in the literature (Andersen, 2004:76). I therefore turned to another profession which places the relationship between the health professional and patient at the centre of the therapeutic process, namely that of counselling.

The terms counselling and psychotherapy are often used interchangeably. Mearns and Thorne (1988:3) adopt the former for relatively short therapeutic encounters (less than one or two years) reserving the latter for more lengthy associations. In my study the participants were generally limited to six sessions with their patients; hence the term “counselling” appeared to be more appropriate. Counselling primarily uses the dialogue between the patient and therapist to heal emotional pain (Overholser, 2004) and views the relationship between the two as the “heart and soul” of counselling (Mahrer & Johnston, 2002:4). Additionally, the quality of the relationship has been shown to be a significant factor in influencing a positive outcome across all forms of counselling (Bachelor & Horvath, 2004:133). As a result of a review of the literature relating to the therapeutic relationship within counselling, two concepts appeared to be the most useful in explicating the sub-category of developing an alliance in theoretical terms. These related to the facilitative attitudes of the individual therapist and the application of these to the therapeutic encounter. Together I have termed these the “physiotherapeutic use of self”. The concepts are now discussed in turn.

i.  The facilitative attitudes of the therapist;

The skills and attributes of the therapist that can facilitate a positive therapeutic relationship have been the topic of some discussion within counselling. Gelso and Carter (1994) proposed that the relationship consists of a reciprocal interaction between:
• a working alliance (the collaboration between the therapist and patient and the emotional bond between them);
• transference configuration (the combination of transference and countertransference) (Section 5.4.4);
• a real relationship (the part that is not transference) (Figure 5.20).

Whilst Gelso and Carter (1994) viewed the working alliance as fundamental to effective therapy, they also considered that it was profoundly influenced by the other components.

It is the “real” relationship component of this model that appears to be the most relevant to theoretically explain the therapeutic alliance in my study. The real relationship is viewed as consisting of genuineness and realistic perceptions. The former refers to the ability of the therapist to be open and authentic, whilst the latter relates to the accuracy of the perceptions the participants have of one another. Such perceptions will result in either positive internal reactions such as liking, caring and interest, or negative reactions such as dislike or disinterest. Both situations have the potential to influence the working alliance.

![Diagram of the psychotherapeutic relationship](image)

**Figure 5.20: The psychotherapeutic relationship (Gelso and Carter, 1994)**

Whilst the real relationship component of the model by Gelso and Carter (1994) provides a useful theoretical framework for the therapeutic alliance, it is not without its critics. Patton (1994) accused it of being vague and ambiguous particularly with regard to the definition of the real relationship. The author questioned whether this is
to be found in the interaction between the two participants or in the genuineness of one or the other. There is also a lack of clarity regarding the “emotional bond” component of the working alliance and how that differs from the positive real relationship (Greenberg, 1994). Greenberg (1994) was also critical of the emphasis on the concept of transference, arguing that all social interaction is invariably influenced by past experiences. How one determines what is distorted in the relationship is therefore challenging. The author also questioned the influence of transference in brief interventions, indicating that it is likely to be more of a feature in longer term psychodynamic relationships.

Criticisms notwithstanding, the concept of a real relationship within physiotherapy appears to reflect in part the perceptions of the participants in my study. Genuineness was evident in their responses, together with a level of realism regarding the patient. What is unclear is the extent to which the patient realistically perceives the physiotherapist and how this influences the overall relationship. The responses of the participants indicate that patients’ attitudes and expectations can be very variable.

The work of Rogers (1957) has also been influential in improving the understanding of the therapeutic relationship. Rogers (1957) was the originator and most eminent practitioner of “person-centred counselling”. This approach emphasises the quality of the relationship between the patient and therapist and values the experience of the individual and their subjective reality (Mearns & Thorne, 1988:5). Person-centred counselling posits that all patients have the inner resources to fulfil their unique potential and it is the role of the therapist to provide the appropriate environment in which this potential can be realised. To this end it has been suggested that six conditions have to exist (Table 5.24). In relation to the therapeutic alliance, conditions three – five are the most pertinent and are considered to be the core conditions for a successful therapeutic relationship (Mearns & Thorne, 1988).

Although the work of Rogers (1957) was focused on counselling, various authors have suggested that the core conditions apply equally as well to the relationships between physiotherapists and their patients (Petitpas & Cornelius, 2004:61; Reynolds, 2004b). Additionally it is recommended that therapists should cultivate the relevant skills to achieve such conditions. Reynolds (2004b:110) has indicated that
such skills can assist therapists to “enter the client’s subjective world without fear or judgement” and she outlined a number strategies for enhancing two-way communication.

<table>
<thead>
<tr>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Two people are involved in the therapeutic encounter</td>
</tr>
<tr>
<td>2 The patient is in a state of incongruence, being vulnerable and anxious</td>
</tr>
<tr>
<td>3 The therapist is congruent or genuine in the relationship</td>
</tr>
<tr>
<td>4 The therapist experiences unconditional positive regard and total acceptance of the patient</td>
</tr>
<tr>
<td>5 The therapist experiences an empathic understanding – perceiving the world as the patient perceives it</td>
</tr>
<tr>
<td>6 The therapist is able to communicate this sensitivity and acceptance to the patient</td>
</tr>
</tbody>
</table>

Table 5.25: Core conditions for a therapeutic relationship (Mearns & Thorne, 1988; Rogers, 1957)

In my study an individual approach was evident and the participants clearly strived to get to know their patients by adopting a variety of strategies. Whilst empathy, genuineness and acceptance were evident in their responses, the extent to which they embraced all the core conditions outlined by Rogers (1957) is questionable. A number of barriers were evident, one of which was the professional persona of the therapist. Affective neutrality was clearly balanced with a delineation of professional and patient roles. Whilst this perhaps reflects the fundamental differences between person-centred counselling and the physiotherapy situation, it is suggested that it may also indicate that additional training is required (Petitpas & Cornelius, 2004:67).

ii. The instrumental use of self

Rowan and Jacobs (2002:5) describe three ways of being a therapist: instrumental, authentic and transpersonal (Rowan & Jacobs, 2002:5). These are associated with three levels of empathy (Table 5.26). My perception is that the approach of the participants most closely reflected the “instrumental” use of self. In contrast to “authentic” and “transpersonal” approaches where there are fewer and no boundaries respectively, in the instrumental way of being the therapist puts on a therapeutic mask, concealing their own emotions, maintaining a persona and developing a “simple” level of empathy (Rowan & Jacobs, 2002:27). Whilst this may initially appear deceitful and controlling, the authors suggested that it is not a
negative view, but may indicate the potential for an increased use of the therapist’s inner self.

<table>
<thead>
<tr>
<th>Instrumental</th>
<th>Authentic</th>
<th>Transpersonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills of the therapist</td>
<td>Therapists technical ability is regarded as possible and desirable</td>
<td>Therapist uses their own emotions, thoughts and reactions in the best interests of the patient</td>
</tr>
<tr>
<td>Aim of therapy</td>
<td>Helping the patient</td>
<td>Liberation</td>
</tr>
<tr>
<td>Boundaries between patient and therapist</td>
<td>Tight</td>
<td>Loose</td>
</tr>
<tr>
<td>Level of empathy</td>
<td>I am with you</td>
<td>I am open to you</td>
</tr>
<tr>
<td>Key words</td>
<td>Assessment, treatment goals, EBP</td>
<td>Authenticity, personhood, intimacy</td>
</tr>
</tbody>
</table>

Table 5.26: Types of therapists’ use of self (Rowan & Jacobs, 2002)

iii. Relationship to patient-centred care

In my study, the participants regarded the development of an alliance as absolutely central to engaging the patient. In theoretical terms, this sub-category is explained by a combination of the facilitative attributes of the therapist and the instrumental use of self which I have termed “physiotherapeutic use of self”. In terms of a visual representation, the alliance provides a framework for the complex responsive process of relating outlined above (Figure 5.21).

![Figure 5.21: Relationship between CRPR and therapeutic use of self](image-url)
Gelso and Carter (1994) indicated that the real relationship develops over time. Initially it is underdeveloped: the patient reveals more about themselves than does the therapist; the therapist has more realistic perceptions of the patient; the patient may struggle to tell their story and the therapist to be themselves. Subsequently the relationship develops, but it is only in the later stages that it gains significance. In my study the participants indicated that time and continuity of care were significant factors in developing an alliance with their patients. As such they suggested that this differentiated their practice from that of other health professions. Whilst it was perceived that patients undergoing a “triage” assessment did not have a different experience, the extent to which this would be reflected in comments from the patients is unknown. Based on the majority of the responses from the participants a temporal element is included in the visual representation of the theory.

5.6.4 Communicative action as a foundation for patient-centred care

In the story line, the development of a working alliance was identified as the ultimate goal of the process of engaging the patient. It was defined as a partnership between the patient and physiotherapist with shared goals of management. This may however represent an “ideal”. Throughout this chapter it is evident that whilst the participants strived to attain a working alliance, there were a considerable number of barriers that impeded their endeavours. These included both external factors, as well as conceptual and professional issues. In addition, it was evident that the participants perceived that the patient themselves could act to facilitate or hinder the process. In attempting to conceptualise the process of engaging the patient in a working alliance, it was evident that its theoretical underpinning had to reflect the “ideal” and the clinical reality. Drawing on the work of Habermas (1987), the theory of “communicative action” appeared to be a useful concept to complete the theoretical conceptualisation. In the theory, a distinction is drawn between two types of action: actions orientated to success and actions orientated towards reaching understanding (Roderick, 1986:109). Both are related to the context in which they occur – either social or non-social (Table 5.27). For the purposes of my study it was the social context that was the most pertinent.
Communicative action aims at reaching a consensus between individuals. It occurs when the interaction between them is not driven by the self-centred goals of success of either party. Instead it is a “mutual and co-operative achievement of understanding” (Roderick, 1986:109). The clinical application of communicative action is outlined in Table 5.28. In contrast, strategic action is orientated towards success. It occurs when one of the individuals strives to attain a pre-determined goal or has an ulterior motive (Grenhalgh, Robb, & Scambler, 2006; Sandman & Munthe, 2010). Strategic action can be considered as open or concealed. In open action the individual overtly pursues their agenda, whilst concealed action is associated with either conscious or unconscious deception. In the former, an individual pursues their agenda whilst letting the other party assume communicative action is occurring. In the latter they deceive themselves that they are engaging in communicative action, when in reality the interest of one party predominates. This can occur for example when the expertise of physiotherapist is acknowledged and accepted without question by both parties (Greenhalgh, Robb, & Scambler, 2006).

<table>
<thead>
<tr>
<th>Action situation context</th>
<th>Action orientated to success</th>
<th>Action orientated to understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non social</td>
<td>Instrumental</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>Strategic</td>
<td>Communicative</td>
</tr>
</tbody>
</table>

Table 5.27: Types of action (Roderick, 1986:109)

<table>
<thead>
<tr>
<th>Actions of patient and physiotherapist</th>
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<tbody>
<tr>
<td>1</td>
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<td>3</td>
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<tr>
<td>4</td>
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<tr>
<td>5</td>
</tr>
</tbody>
</table>

Table 5.28: Clinical application of communicative action (Sandman & Munthe, 2010)
i. **Relationship to patient-centred care**

Sandman and Munthe (2010) argued that communicative action may represent a “rosy” picture of shared decision-making which does not reflect clinical reality. Instead they proposed their model of *professionally driven best interest compromise* which involves open strategic action. In this scenario, the patient is aware that the health care professional is acting strategically. As previously discussed (Section 5.5.3), the model does appear to reflect the findings in my study, however it is also evident that the participants made considerable efforts to involve their patients in the decision-making process. In a study of consultations in primary care, Greenhalgh et al., (2006) found that both doctors and patients adopted a mix of communicative and strategic actions. Although strategic action was instigated predominantly by the doctor, this was not always the case and depended on individual motivations. Typically open or concealed strategic action was utilised by the doctor in response to a lack of time. In my study it is evident that there were a considerable number of personal, professional and organisational barriers to patient engagement. Whilst a combination of communicative and strategic action is likely, my perception is that there is a greater tendency for strategic action in current musculoskeletal physiotherapy practice.

### 5.6.5 Final conceptualisation

It is proposed that in this study the conceptual foundation for PCC in musculoskeletal physiotherapy is drawn from a number of different disciplines and philosophies. The role of social interaction in creating meaning is explicated by *complex responsive processes of relating*, the therapeutic alliance is explained by the *physiotherapeutic use of self*, and the *theory of communicative action* provides a theoretical underpinning for the process of *engaging the patient*. This is diagrammatically represented in Figure 5.22.
Figure 5.22  A theoretical basis for patient-centred care

The findings chapter has identified that the process of engaging the patient in a working alliance is a complex process influenced by numerous factors. The patient and physiotherapist start the process with their own individual knowledge, expectations and attitudes. The social interaction between them is influenced by contextual factors such as resources, the services offered to patients with LBP and the support and supervision in the physiotherapy department. In addition the professional role of the physiotherapist is identified as a significant feature. Underpinning the process of getting the patient “on-board” with their management is physiotherapist’s ability to communicate. This was evident throughout each of the sub-categories and the core category. This does not occur in isolation but permeates the whole process. Figure 5.23 combines the theoretical conceptualisation outlined above, with the influencing factors, to present a substantive theory of patient centred care in musculoskeletal physiotherapy practice from the perspective of the physiotherapists in this study.
Reflection on the Findings

In this chapter the findings of the study have been presented and discussed in relation to the relevant literature. Although the analysis and findings have been presented separately, in reality they occurred simultaneously. As detailed in the audit trail (Section 4.10.2), my theory evolved through several stages. I was advised early in the analysis to start writing the categories as this would assist in their development and conceptualisation. Initially I found it challenging to articulate the concepts when they appeared to be in such an embryonic state. As a researcher with a strong background in positivism, the level of ambiguity and uncertainty encountered in the early stages of the analysis was uncomfortable. This issue was one I had considered prior to the study, particularly in relation to the level of abstract thinking required for theoretical conceptualisation (Section 3.5). Despite an awareness of the common pitfalls of grounded theory (GT) (Hutchinson, 1993; Kennedy & Lingard, 2006) I recognise that I inadvertently fell into a number of them.
In the initial stages of data analysis, premature closure was an error. It is suggested that this results in a theory that is inadequate (Hutchinson, 1993). I subsequently realised that at that stage my analysis was superficial and incomplete.

Another error in the early stages was to apply pre-determined themes rather than themes that emerged from the analysis. This was evident in some of the titles I applied to the early concepts and categories (e.g. psychosocial factors) (Section 4.10.2). Increasing confidence and familiarity with the process of analysis assisted me to “let the data speak for itself”.

As the categories became clearer, I turned to the literature to conceptualise the data and work towards an explanatory theory. Whilst I embarked upon the study with a sound knowledge of the available literature in relation to patient-centred care, I had to explore a new body of literature with which I was unfamiliar. I became absorbed by this process and the literature dominated my initial writing of the findings. The data was presented in a supporting role to the literature. As a result of my increasing familiarity with GT, coupled with advice from supervisors, the data and literature assumed their rightful positions.

The theoretical conceptualisation of the theory was the most demanding part of the process. Theoretical conceptualisation is integral to GT as without it there is no theory. It is acknowledged that this stage of pulling the theory together is the most challenging part of the research. Birks and Mills (2011:113) suggested that the process is “intellectually and emotionally demanding” and this was certainly my experience. It is here that I recognise how my position as the researcher influenced my interpretations. Because of our shared professional backgrounds, I felt a strong connection to the participants. As such I was aware that I had a responsibility to them. I wanted to ensure that I did not misrepresent them in any way. Consequently, it was challenging to move from the raw data to more abstract thinking. I found myself constantly revisiting the transcribed interviews, to be certain that my conceptualisation was supported by the data. Whilst immersion in the data and constant comparison are hallmarks of GT analysis (Section 3.4.3), my perception is that initially I was so tied to the data that I could not move to the next level of abstraction. Charmaz (2006:51) suggested that “being critical about your data does not necessarily mean being critical of your
research participants" and this advice certainly assisted with my theoretical conceptualisation.

- Identification of the core category is integral to GT. As discussed in the audit trail (Section 4.10.2), committing to the core of engaging the patient took a considerable length of time. Whilst the delay was due in part to my inexperience of GT techniques, I also recognise that I was somewhat uncomfortable with this concept. The previous title of striving for congruence implied that the participants worked hard to reconcile their goals with their patients’ expectations. I somehow felt that engaging the patient implied a level of inflexibility and manipulation. My unease subsided as I recognised that it met all the criteria for a core category. Through conceptualising it in relation to the literature, I also recognised that physiotherapy was not unique in struggling with the concepts of goal-setting and decision-making in relation to their professional role.

The process of analysis and conceptualisation was not associated with any “eureka” moments. Instead prolonged engagement with the data over many months led to a gradual emergence of the theory. A number of strategies served to enhance my theoretical sensitivity and facilitated the integration of my theory.

- Memoing is considered to be fundamental to GT and as such should occur throughout the research process (Birks & Mills, 2011:40). Despite my initial concern regarding the level of self-discipline required for memoing (Section 3.5.3), I kept a record of my deliberations about the data from an early stage. This proved invaluable in developing the categories and identifying the connections between them. The memos grew in size and complexity as the literature was woven into the findings. As such they ultimately provided the framework for the final theory.

- I also found the use of diagrams particularly helpful. As evident in the audit trail (Section 4.10.2), a visual representation of the theory was constructed at each stage of the evolution of the theory.

- Presentation of the findings at conferences required me to clarify my thought processes and clearly articulate my theory. Whilst I felt incredibly anxious in presenting a “work in progress”, the feedback I received was very helpful and as such my confidence improved. The development of the theory, particularly in
terms of its conceptualisation, is very evident in the difference between the poster presentations at the Kinetic Control and Manipulation Association of Chartered Physiotherapists conference in October 2009 and the World Confederation of Physical Therapists in June 2011 (Appendices 14 and 15).

- Finally, the development of the theory was profoundly influenced through discussions with my supervisors. I was repeatedly challenged to develop the categories, identify relationships, conceptualise the findings, avoid the pit-falls associated with GT and find my own voice rather than rely on the literature.

5.6.7 Summary

This extensive chapter has detailed the findings of the study in relation to the research question. Patient-centred care in musculoskeletal physiotherapy has been conceptualised as a process of engaging the patient in a working alliance. Three social interactions contribute to the process; interpreting the problem; reconciling perspectives and developing an alliance. It is proposed that the process is situated in the theoretical framework of complex responsive processes of relating, the physiotherapeutic use of self and the theory of communicative action. The next chapter considers the implications of the findings for physiotherapy practice.
Chapter 6
Final Discussion

6.1 Introduction

The study set out to answer the research question:

**What are the perceptions of patient-centred care in contemporary musculoskeletal physiotherapy practice?**

In addressing the question, the findings have potentially provided a broader picture of contemporary musculoskeletal practice. The challenge at this stage is to tease out the concepts that particularly relate to patient-centred care (PCC). The findings suggest that the ultimate goal of engaging the patient is a working alliance, characterised by a partnership between the patient and physiotherapist. It is acknowledged that achieving a shared understanding of beliefs regarding the patient’s problem, the reason they are attending for treatment and an intervention that is mutually acceptable to the patient and physiotherapist is a considerable challenge (Klaber Moffett et al., 2006:114). This is clearly reflected in the findings of my study. Forbat et al., (2009:84) suggested that such a process requires “understanding” and this perhaps provides the basis for a discussion on the implications of this study.

This chapter starts by highlighting the key issues identified by the participants as influencing their ability to engage their patients in a working alliance. It then considers the clinical implications of these issues and suggests some practical methods by which they could be addressed. In considering the implications I was mindful of the current environment in the National Health Service (NHS). Resources are scarce, cut-backs prevalent and the future shape of services uncertain. This will inevitably impact on the availability of funding and time for professional development. I was also aware of the continuing shift of services from secondary into primary care, the influence an aging population with its accompanying increase in chronic musculoskeletal disorders and the move for physiotherapists to have a greater involvement in health promotion. The chapter considers the strengths and limitations of the study and provides some recommendations for further research. Finally the plans for the dissemination of the findings are discussed.
The findings suggest that there are a number of key issues that impact on the ability of the participants to engage their patients in a working alliance. These are summarised in Table 6.1 along with the category where they originated. Issues one to seven appear to be focused at the level of the interaction between the patient and physiotherapist; issues eight and nine relate more to local and organisational factors; finally issues 10 and 11 recognise the influence of the problem of back pain itself and the lack of national (and indeed international) consensus for its management.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A predominantly biomedical approach to assessment with limited questioning of the patient’s belief system and other potential psychological factors</td>
</tr>
<tr>
<td>2</td>
<td>The significant influence of patient expectations on assessment and management</td>
</tr>
<tr>
<td>3</td>
<td>The participant’s attitudes and expectations of their role in managing chronic low back pain (LBP)</td>
</tr>
<tr>
<td>4</td>
<td>The lack of evaluation of strategies in relation to information-giving and self-management</td>
</tr>
<tr>
<td>5</td>
<td>The influence of the therapeutic alliance</td>
</tr>
<tr>
<td>6</td>
<td>The key role of the individual physiotherapist as a person and as a professional</td>
</tr>
<tr>
<td>7</td>
<td>The challenge of goal-setting and incorporating the patient’s perspective into the decision-making process</td>
</tr>
<tr>
<td>8</td>
<td>The constraining influence of limited resources</td>
</tr>
<tr>
<td>9</td>
<td>The lack of co-ordination between services for patients with LBP</td>
</tr>
<tr>
<td>10</td>
<td>The lack of clinical and professional guidance regarding the management of chronic LBP</td>
</tr>
<tr>
<td>11</td>
<td>The uncertainty surrounding the management of chronic LBP</td>
</tr>
</tbody>
</table>

Table 6.1: Key issues in engaging the patient

My perception is that the 11 issues can be amalgamated into the following broad areas:

- Identifying and addressing psychological factors
- Facilitating the decision-making process
- Establishing a conducive learning environment
- Facilitating self-management
- Enhancing communication
These are now discussed in light of the relevant literature and theoretical conceptualisation and the implications are highlighted.

6.2. Identifying and addressing psychological factors

It is evident from the findings that the perceived level of incompatibility between their own belief system and that of their patients was a source of considerable frustration for the participants. Patients’ expectations were recognised as being very variable with expectations of a cure commonplace. Such expectations were perceived to be shaped by numerous factors including the western biomedical perspective of pain, often propagated by the numerous health and alternative therapists that are involved in the management of back pain. Despite the considerable evidence for the influence of psychosocial factors in ongoing pain and disability, the questioning of psychological factors appeared unsystematic and variable between participants. A number of factors have been proposed as contributing to this issue including the format of the initial assessment with its focus on the identification of impairments, the lack of training and the biomedical orientation of the participants.

At the macro level, a multimedia public health campaign in Scotland (Waddell, O'Connor, Boorman, & Torsney, 207) utilising radio adverts, a dedicated website and information leaflets for individuals with LBP, resulted in a significant change in beliefs relating to its management. A particular feature was the policy of ensuring that patients received a consistent message from all the health professionals involved in their care. In the absence of such an initiative in England, it is unlikely that there will be any changes in the public perceptions of LBP in the foreseeable future. The implication is that changes in practice will have to be implemented at the micro level.

**Implication 1:**
Physiotherapists should recognise the considerable influence of the patient’s belief system upon the outcome of physiotherapy

In addition to the limited questioning in relation to beliefs, the extent to which the participants explored their patients’ experience of pain is questionable. There is evidence that chronic LBP has a profound impact on a person’s sense of identity (Crowe, Whitehead, Gagan, Baxter, Pankhurst, & Valledor, 2010). Lundberg, Styf,
and Bullington (2007) suggested that patients with chronic pain may “suffer from a deep existential crisis” rendering them unable to identify or work towards a goal. De Souza and Frank (2010) found that chronic LBP had profound implications for the patient’s personal and social relationships, including work. A predominantly biomedical focus, with an inadequate and incomplete assessment of these factors, is likely to have implications for engaging the patients in their management programme.

**Implication 2:**
Physiotherapists should attend to the patient’s experience of pain in the context of their everyday life

### 6.2.1 Suggestions for practice

Watson (2000:86) suggested that physiotherapists’ psychological evaluation of a patient is often “implicit” and that experienced clinicians may do this intuitively. However, the author argued that this approach is insufficient and the initial assessment should be broadened to encompass a more formalised and overt questioning of such factors. Daykin and Richardson (2004) indicated that modifying the management approach of qualified physiotherapists to encompass a more psychosocial perspective is likely to be challenging. Whist I support the recommendation of the authors that undergraduate curricula should embrace such an approach, this still leaves the issue of guidance for qualified clinicians, who may not perceive the need for additional training. In my own University, one of the most popular postgraduate musculoskeletal modules aims to enhance the assessment and management of patients with neuromusculoskeletal dysfunction of the lower quadrant. Currently, this module incorporates only a minimal discussion of psychosocial factors. It is evident therefore that a predominantly biomedical approach continues to be perpetuated at postgraduate level. I am also aware that the appointment slots for out-patient musculoskeletal physiotherapy are 30 minutes at the most. Any additional questioning may not be welcomed, or embraced, by physiotherapists. Indeed, the participants indicated that they struggled to complete their assessment in the allotted time. My suggestion is that this issue needs to be addressed at two levels: the micro or clinical level and the macro or organisational level.
i. **Clinical level**

Afrell and Rudebeck (2010:281) suggested that there is a requirement for “an easily applicable link between the biopsychosocial perspective and the physiotherapist’s professional stance in the clinical encounter”. The term “yellow flags” has been applied to psychosocial factors which may increase “the risk of developing or perpetuating long-term disability and work loss associated with low back pain” (Kendall, Linton, & Main, 1997:1). It is suggested that the factors can be assessed through the use of a screening questionnaire, a clinical interview with a suitably qualified clinician, or a combination of the two. It is also recognised that the use of a few simple questions can assist clinicians in determining whether a patient is at risk of a poor outcome due to adverse psychosocial factors. Despite being advocated in 1997 (Kendall et al., 1997), my own perception is that the screening questionnaire is not routinely used in clinical practice and additional training in psychosocial assessment is not common. In view of the constraints on their practice identified by the participants, I suggest that an easily applicable link could be a pre-treatment information pack supplemented by some additional questions. The pre-treatment package could consist of:

- Information detailing the structure and format of the initial appointment. This could include a paragraph indicating that patients will be provided with advice and a home programme to help them control their symptoms. Johnston, Gilbert, Partridge and Collins (1992) demonstrated that the inclusion of this information resulted in higher levels of perceived control and a tendency to higher level of satisfaction. Although the letter did not result in any differences in terms of accuracy of expectations, the authors suggested that this was because many of the patients had not experienced sufficient physiotherapy to make this judgement.

- A simple pain beliefs questionnaire, such as the one on the Working Backs Scotland website (www.workingbacksscotland), could provide a useful overview of a patient’s attitude towards their back problem (Appendix 16). Patients could be asked to complete it prior to their first appointment. The accompanying explanation to the questionnaire indicates that more responses to “disagree” and “disagree strongly” suggest positive beliefs that the patients back problem will settle. My perception is that the extent to which that information is helpful prior to the first appointment is questionable. It was suggested that a key stage in
engaging the patient is the acceptance by the patient that they have a chronic problem for which there is no cure but which they can control (Section 5.5.4.). The responses to the questionnaire have the potential to provide the physiotherapist with an insight into the extent to which this has occurred.

The inclusion of some simple additional questions in the initial assessment also has the potential to provide the physiotherapist with invaluable information relating to the patient’s experience of pain and expectations of physiotherapy (Table 6.2). The questions have been modified from the original “yellow flags” (Kendall et al., 1997) to reflect the findings of my study. The focus of the original questions was related more to employment and included questions relating to time off work, the response of the patient’s employer and an anticipated date of return to work.

<table>
<thead>
<tr>
<th>Can you tell me about your experience of your back problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How has it affected your life?</td>
</tr>
<tr>
<td>How do you feel about the treatment you have received so far?</td>
</tr>
<tr>
<td>What treatment do you expect?</td>
</tr>
<tr>
<td>How much benefit do you expect to get from physiotherapy?</td>
</tr>
</tbody>
</table>

Table 6.2: Supplementary questions

Whilst the participant’s were concerned that questions relating to psychological factors would “open a can of worms” (Section 5.2.4), Main, Foster and Buchbinder (2010) stressed that it is imperative that any misunderstandings about pain are addressed to facilitate the patients’ management. Afrell and Rudebeck (2010:281) concurred by suggesting that patient’s own perceptions on the “meaning of pain and its possible causes might, by extension, produce conditions for more effective treatment”. Interestingly the authors indicated that the dominance of a biomedical perspective may lead physiotherapists to question the justification for such questions leading to more simplistic solutions of symptomatic relief “which are no solutions at all” (Afrell & Rudebeck, 2010:287). Reynolds (2004b:114) has suggested that therapists may avoid emotionally sensitive issues as they feel ill-equipped to deal with them. However, she has argued that effective communication skills, in particular listening attentively and offering appropriate explanations, can make a considerable difference to the ability of patients “to deal with crisis and cope with change”.

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ii. **Organisational level**

Whilst the implementation of a pre-treatment information pack would not require significant organisational changes, identifying and addressing psychosocial factors in the workplace requires support. Organisational level issues such as the limitations to the number of treatment sessions and length of appointments can act as barriers to effective care (Reynolds, 2004b:113). The flexibility to adjust the timing of treatment sessions to accommodate individual patient’s needs is recommended, however this may be unrealistic in busy out-patient departments. In addition the support of the whole team is important. Reynolds (2004b:114) has suggested that therapists cannot work in isolation when addressing sensitive issues. They require appropriate supervision and mentoring to avoid emotional exhaustion. The department in which the study was undertaken offered a comprehensive support system (Section 5.5.5), despite this it was still evident that some of the participants experienced a number of issues when it came to addressing psychological factors.

My perception is that changes in this area of practice have to be driven by the Chartered Society of Physiotherapy (CSP) policy, implemented by universities in their undergraduate and postgraduate curricula and supported in the workplace. Standard five of the CSP Core Standards of Practice (2005) relates to assessment. Whilst the criteria refer to the patient’s perceptions of their needs, their expectations and presenting condition, the guidance provided is minimal. In relation to expectations for example, it states that these “*may be expressed as anticipated gain from physiotherapy*”. My impression is that this does not place sufficient emphasis on the assessment of potential psychological influences on patients’ problems. Unless this is made more overt, it is unlikely that university education will change. In my own university the most popular modules are predominantly skill-based. Unless there are policy changes it is unlikely that the ethos of these modules will undergo any significant alterations. The demand for places is high and feedback is excellent. Finally it is suggested that clinicians need to be part of an “*emotionally literate work context*” (Reynolds, 2004b:114) in which the whole team are mindful of potential psychological issues and provide appropriate support. Such an approach requires appropriate knowledge and skills and sufficient treatment time.
6.3 Facilitating the decision-making process

It was evident from the findings that goal-setting and incorporating the patient’s perspective into the decision-making process was integral to PCC. However, it also presented the participants with a number of challenges. This issue is reflected in the current literature. Leach et al., (2010: 168) suggested that there is “a demand for an objective, theoretically based structure to facilitate an effective process of patient-centred goal setting”, a sentiment echoed by Siegert and Taylor (2004).

**Implication 3:**
An appreciation of the theoretical basis of goal-setting may enhance the ability of physiotherapists to engage their patients in a working alliance

Patient participation in the decision-making process was positioned more at the involvement rather than partnership end of the decision-making continuum and was associated with a number of tensions. Whilst patient participation and shared decision-making is advocated by policy documents, and is integral to models of PCC, this has to be balanced with the professional role of the physiotherapist and the expectations of their patients.

**Implication 4:**
Physiotherapists have to strike a balance between therapist-led and partnership approaches to decision-making

6.3.1 Suggestions for practice

i. **Theoretical basis for goal setting**

In an attempt to provide a sound theoretical basis for goal-setting, Siegert and Taylor (2004) focussed on three approaches drawn from social psychology (Table 6.3). Whilst it is acknowledged that most of the studies in this area have not been undertaken in a rehabilitation setting, the theories do provide a useful framework for musculoskeletal physiotherapists. The importance of goals based on an understanding of the personal issues for individual patients is evident.
### Social Psychological Theory and Goal-Setting (Siegert & Taylor, 2004)

In a review of the literature related to rehabilitation and health-related self-management, Scobbie and Wyke (2009) identified five theories of behaviour change relevant to goal setting. Based on a detailed analysis of the evidence, the authors concluded that three of the models (self-efficacy component of Social Cognitive Theory, Goal-setting Theory and Health Action Process Approach) were particularly pertinent for goal-setting comprising of a number of overlapping constructs which are applicable to the clinical setting (Table 6.4).

<table>
<thead>
<tr>
<th>Social Psychological Theory</th>
<th>Key Constructs</th>
<th>Implications for Goal-Setting</th>
</tr>
</thead>
</table>
| Self Determination (Deci and Ryan) | - Individuals are intrinsically rather than extrinsically motivated  
- Humans have three fundamental needs: autonomy, competence and relatedness | - Therapists need to get to know the patient as a person in order to set intrinsic and meaningful goals  
- Higher levels of autonomy and competence are required for motivation. However patients will need support.  
- Goals should be challenging |
| Subjective Goals and Well Being (Emmons) | - Personal strivings are a stable feature of personality and will influence behaviour  
- The extent to which individuals achieve these goals will impact upon their well-being and their positive or negative emotional state | - Emotions and feelings are integral to goal setting  
- Goals are hierarchical – lower level goals should be organised to achieve higher level or more abstract goals that are personally meaningful |
| Temporal Influences (Karniol and Ross) | - An individual's past plays a major role in their ability to consider new goals and imagine a possible future  
- Emotional factors are important in this process | - Knowledge of a patient's past can assist therapists in formulating future goals |

Table 6.3: Social psychological theory and goal-setting (Siegert & Taylor, 2004)
Table 6.4: Models of behaviour change applied to goal-setting (Scobie & Wyke, 2009)

From the review, the authors proposed a framework for goal-setting in rehabilitation (Figure 6.1), in which key constructs from the models are applied to the two phases of the Health Action Process Approach (HAPA). In the proposed framework behaviour change occurs in two phases. In the motivational phase there is the intention to achieve a goal whilst in the action phase the actions are implemented. In the first phase it is suggested that the therapist should explore the patient’s self-efficacy and expectations of the outcome of the goal-related behaviour (Scobie & Wyke, 2009). This may be particularly useful where patients are finding it difficult to identify goals. If the patient does not believe that they can implement the strategies suggested by the physiotherapist then they are unlikely to try them. To this end a simple analogue scale may be a useful tool (Figure 6.2). Gladwell (2006:46) has suggested that a rating of self-efficacy of less that 50% is likely to be associated with failure and reinforcement that the patient was correct in doubting their ability. The physiotherapist can discuss the reasons why the patient placed themselves at the level they selected and explore what would be required for an increase in score.
The patient’s perceptions of the outcome of the goal should also be determined. Questions such as “if the strategies we have discussed are successful, what will be different in your life?” or “what are the likely benefits?” may be helpful in moving from the motivation phase into the goal-setting phase. The physiotherapist has a role in emphasising positive outcomes such as a decrease in symptoms or an increase in quality of life (Hammond & Niedermann, 2010:82). It is suggested that perceived self-efficacy and positive outcome expectancies work together and can be a significant factor in determining an intention (Schwarzer, Ziegelmann, Luszczynska, Scholz, & Lippke, 2008).

The framework indicates that physiotherapists should consider the particular characteristics of the goal itself. The acronym “SMART” (Specific, Measurable, Achievable, Rewarding/Realistic/Relevant, Time-limited) (Gladwell, 2006:40) is well known, but it is evident that the participants did not integrate this approach into their goal-setting process. This is supported anecdotally by feedback from other therapists undertaking postgraduate studies at my university and through my observation of patient-therapist treatment sessions. This may be because the characteristics of SMART goals have not been clearly defined and they are perceived as being challenging and time-consuming to devise (Bovend'Eerdt, Botell, & Wade, 2009).
In response to the issues associated with goal–setting, Bovend'Eerdt et al., (2009) developed a new method for writing SMART goals in an interdisciplinary rehabilitation setting (Figure 6.3). In addition to the steps outlined, they suggest that goals can be weighted according to their importance or difficulty using a three point scale. Whilst Bovend'Eerdt et al., (2009) suggest that the approach is easy to implement and can apply to most clinical situations, it is based on a number of assumptions which were not met in my study and this may mean that its applicability to musculoskeletal out-patient practice is limited (Table 6.5).

![Figure 6.3: Flow chart for writing goals (Bovend'Eerdt et al., 2009)](image)

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Applicability to my study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Rehabilitation is taking place in the biopsychosocial model</td>
<td>A biomedical model predominated</td>
</tr>
<tr>
<td>2  Rehabilitation goals are set at the activity and participation levels of the WHO ICF</td>
<td>Goals appeared to be set at the impairment and activity levels</td>
</tr>
<tr>
<td>3  The patient’s wishes and expectations have been determined</td>
<td>There was limited exploration of the patient’s wishes and expectations</td>
</tr>
<tr>
<td>4  The team will only set attainable and realistic goals</td>
<td>Goal-setting was uni-professional activity</td>
</tr>
</tbody>
</table>

Table 6:5 Assumptions underpinning the goal-setting process (Bovend'Eerdt et al., 2009)
In the framework proposed by Scobbie and Wyke (2009), it is suggested that planning how patients will implement the goal-directed behaviour, exploring strategies for coping with set-backs and how confident they are in implementing such strategies, may assist with the activation and continuation of the goal-related behaviour. Action planning involves a cognitive component of thinking through how the patient will follow through with the behaviour. Schwarzer et al., (2008) suggested that at this stage a distinction should be drawn between action and recovery self-efficacy. This is because the meaning of self-efficacy may vary depending on context. Whilst a patient may be confident they can implement a particular strategy, they may feel less confident in recovering from a set-back. In a series of three longitudinal studies Schwarzer et al., (2008) explored the validity of the HAPA. They found that action planning spanned the divide between intention and behaviour and this construct together with recovery self-efficacy was a predictor of adherence to exercise. Finally, the provision of feedback is important for continued motivation. Progress towards goals should be reviewed so that problem-solving strategies can be discussed and goals modified or progressed (Gladwell, 2006:50).

My impression is that the framework proposed by Scobbie and Wyke (2009) provides a simple and clinically applicable tool which has the potential to assist physiotherapists in the process of goal-setting. It should however be recognised that of the 24 papers that met the inclusion criteria set by Scobbie and Wyke (2009), only five were related to musculoskeletal disorders. In addition, the authors acknowledged that contextual factors were not considered in the framework and these can act as considerable barriers or facilitators to behaviour change.

It was evident that for the participants in my study goal-setting was vital in order to engage the patient in a working alliance. It was also apparent that the process was underdeveloped and this appears to be an issue across the different specialities within physiotherapy. When exploring the reasons behind this, the education of physiotherapists has to be considered. In my own university the topic receives minimal attention at undergraduate level and until recently, none at all at postgraduate level. Feedback from a recent postgraduate teaching session where the theoretical basis of goal-setting was discussed indicated that this information was potentially valuable to their practice. My perception is that it would not take a significant change in practice in order to integrate a more effective goal-setting
process. Getting to know the “patient as a person” (Section 5.5.3) was identified by the participants as important in engaging them in their management. Translating this knowledge into goal-setting process is the first step in devising individual, success orientated, attractive, achievable and positive goals (Hammond & Niedermann, 2010:80). My perception is that more attention to the attributes of the goal itself and a consideration of self-efficacy would greatly enhance the ability of physiotherapists to engage their patients in a working alliance.

ii. **Striking a balance in the decision-making process**

To date the majority of the literature relating to decision-making in physiotherapy has focused on “how” this occurs in practice (Section 5.5.3). There is very little guidance available to assist physiotherapists in striking a balance between a therapist-led and partnership approach, confirming that decision-making is “the neglected second half of the consultation” (Elwyn et al., 1999:481). The exception is a framework proposed by Bainbridge and Harris (2005) which integrates PCC, informed choice and evidence-based practice. In addition, strategies that can be utilised in the implementation of the framework are identified (Table 6.6). The authors also recognised that the physiotherapist requires effective interpersonal and communication skills to facilitate the patient to participate in the decision making process.

Whilst Bainbridge and Harris (2005:79) urged physiotherapists to “embrace” the model and “evaluate its merits in practice”, the findings of my study suggest that this does not reflect current practice. Whilst the participants strived to create a partnership with their patients, the extent to which the remaining competencies were achieved is questionable. Questioning the patient as to their preferred level of involvement has also received some criticism in the literature. Elwyn et al., (1999) posited that it is irrational to ask patients about their preferred role in decision making until they are aware of the all the issues surrounding the choices available to them. They also suggested that evidence surrounding the majority of clinical decisions is lacking. In the case of LBP this is a particular issue making it challenging for physiotherapists to meet competencies five and six. Decision-making in primary care
has also been identified as problematic (Elwyn et al., 1999) (Table 6.7) and my perception is that these issues are similar to those experienced by the participants.

<table>
<thead>
<tr>
<th>Competency for shared decision making</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| 1 Develop a partnership with the patient | • Facilitate trust and encourage active participation  
• Minimise the power differential |
| 2 Establish the patient’s preferences for information | • Identify the patient’s preferred learning style |
| 3 Establish the patients’ preferences for a role in decision making | • Ask the patient if they would prefer to actively participate in decision making or leave it up to the therapist |
| 4 Ascertain and respond to patient’s ideas, concerns and expectations | |
| 5 Identify choices and evaluate research evidence in relation to the individual patient | |
| 6 Present or direct the patient to evidence taking into account competencies 2 and 3 | • Demonstrate sensitivity in presenting the information to ensure it does not support the therapist’s choice |
| 7 Make or negotiate a decision in partnership with the patient and resolve conflict | • Identify decisional conflict and work with the patient to resolve the issue  
• Assist the patient to reflect upon the impact of alternative choices |
| 8 Agree on an action plan and complete arrangements for follow up | • Collaborative discussion |

Table 6.6: Framework for informed shared decision-making (Bainbridge & Harris, 2005)

<table>
<thead>
<tr>
<th>Problems in implementing shared decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 It is time consuming</td>
</tr>
<tr>
<td>2 It threatens the power relationship between the patient and health professional</td>
</tr>
<tr>
<td>3 Treatment decisions are coloured by prior experiences of both the participants</td>
</tr>
<tr>
<td>4 There is a lack of training and experience in shared decision-making</td>
</tr>
<tr>
<td>5 Health professionals do not possess the skills to involve patients in decision-making</td>
</tr>
<tr>
<td>6 There is a lack of evidence regarding the risks and benefits of individual interventions</td>
</tr>
<tr>
<td>7 Health professionals do not possess the skills to convey information about risks and benefits</td>
</tr>
<tr>
<td>8 It is perceived that patients do not appreciate the “health professional uncertainty” that shared decision-making may convey</td>
</tr>
</tbody>
</table>

Table 6.7: Problems preventing shared decision-making (adapted from Elwyn et al., 1999)
In the light of the issues identified, what is the way forward for musculoskeletal physiotherapists? The answer to this may come from two perspectives; the development of formal support systems and the interaction between the patient and therapist. In the long term it is likely that the increasing development of support systems will assist the process of decision-making. Support systems can be broadly divided into two:

- systems designed to help patients in difficult decisions, known as decision aids;
- systems designed to assist clinicians to incorporate patient preferences into their management programmes (Ruland & Bakken, 2002).

Decision aids are self administered tools that prepare patients for making informed decisions about medical tests or treatments. They are designed to increase a patient’s awareness of expected outcomes and their own personal values (Sepucha & Mulley, 2003). They are particularly useful when decisions are challenging, for example where there may be considerable differences in outcome between treatments. Traditionally they have been used for decisions within one episode of care (Ruland & Bakken, 2002). Whilst decision aids can assist in improving the quality of decisions, Sepucha and Mulley (2003) identify two limitations. Firstly there has to be a recognition that there is a decision to be made and secondly decision aids do not address the issue of implementation of the decision. As previously discussed, information relating to choices for the treatment of LBP is limited. In addition, physiotherapists managing patients with LBP, particularly chronic pain, have to attend simultaneously to a multiple and complex range of biopsychosocial problems presented by their patients.

The second support system for patient preference-based management is designed to take into account such complexities. Ruland and Bakken (2002) outline a conceptual model comprising of eight conditions that need to be considered in the development of a decision support system. Again the extent to which knowledge and evidence regarding the management of back pain is detailed and sophisticated enough to meet the criteria for such a system is questionable. For example, step three involves defining the dimensions of the decision problem so that patient preferences can be elicited. Available options have to be presented along with the
benefits and potential harm. In the presence of limited options and a lack of empirical evidence, such a support system may have limited applicability.

The development of decision aids is a priority for the NHS and to date three phases have been completed, although only the results for the first phase are currently available on the NHS Direct web site (www.nhsdirect). Phase four involves the creation of a decision aid relating to “Prolapsed discs and other causes of chronic LBP”. The extent to which a decision aid for back pain will facilitate patients and physiotherapists to share decisions remains to be seen but studies appear to support their role in this process (Ruland & Bakken, 2002).

Whilst decision aids may assist in the long term, it may be that the personal interaction of the patient and physiotherapist provides the most promise for striking a balance. Taylor (2009:151) has argued that the relationship is the “cornerstone of an effective and humane healthcare system”. Whilst patient participation should be the overall goal of physiotherapy (Larsson et al., 2010a), the physiotherapist has to be sensitive to the preferred style of the patient, recognise their individual needs, concerns and values and respond appropriately (Krupat, Rosenkranz, Yeager, Barnard, Putnam, & Inui, 2000; Taylor, 2009). Such sensitivity requires well-developed communication skills. Reynolds (2004b:116) has suggested that “listening skills and responsiveness” are essential for the development of a working alliance. In particular she emphasised the importance of “active listening”. It is suggested that the attainment and enhancement of such skills requires not only training and practice, but also self-awareness on behalf of the therapist (Petitpas & Cornelius, 2004:67). My perception is that educational institutions again have a role to play in developing the appropriate skills in physiotherapists.

Training programmes have been urged to promote self-understanding and awareness in their students in order to enhance their communication skills (Petitpas & Cornelius, 2004:68). Dobie (2007) has argued that teachers have a responsibility to facilitate self-awareness in their students indicating that this has the potential to provide clinicians with a deeper understanding of the patient-therapist relationship. To this end a number of strategies have been recommended. These include the overt incorporation of reflection and discussion throughout the curriculum; sharing of beliefs, and feedback on personal styles of interaction (Dobie, 2007; Petitpas &
Cornelius, 2004). For qualified physiotherapists, strategies such as receiving feedback on video or audio-taped interactions, or the use of reflective diary may be useful. It is also recognised that perhaps the most effective method for enhancing self-awareness is mentoring and supervision in the work place (Petitpas & Cornelius, 2004).

6.4 Establishing a conducive learning environment

The focus of the sub-category of reconciling perspectives was on modifying expectations to facilitate subsequent management. This was addressed primarily through the provision of information. Whilst the participants used the term “education”, it was evident that the provision of information was more concerned with enhancing knowledge, rather than facilitating behaviour change. It was also apparent that the participants did not appear to assess individual patient requirements for information, or evaluate its effectiveness. Trede (2000) has suggested that such an approach implies a number of assumptions:

- patients lack knowledge about their problem, if corrected compliance will follow;
- patients make rational decisions about their health based on scientific advice;
- external influences do not restrict patients’ choice of behaviour;
- patients have high levels of self-confidence and self-efficacy.

Elwyn et al., (1999) also recommended that the patient’s understanding of the information provided to them should be ascertained, as this can vary considerably in relation to apparently straightforward information. As a result of a small study exploring the educational component of physiotherapy practice, Trede (2000) concluded that the educational skills of her participants were not based on educational theory but learnt through clinical experience. The findings of my study appear to reflect this stance.

**Implication 5:** Physiotherapists should tailor education according to the needs of an individual patient
6.4.1 Suggestions for practice

The suggestions for practice are considered in relation to three main areas; identifying patients’ needs; learning theory and learning styles.

i. Identifying needs

The provision of information, advice and exercise can potentially lead to resistance if an individual’s requirements for information are not identified. It is therefore recommended that needs should be identified and targeted appropriately (Table 6.8) (Hammond & Niedermann, 2010).

<table>
<thead>
<tr>
<th>Components of effective education</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying needs</td>
<td>The physiotherapist should consider the priorities of education:</td>
</tr>
<tr>
<td></td>
<td>• Is it cognitive change where the focus is on improving knowledge and understanding of LBP</td>
</tr>
<tr>
<td></td>
<td>• Is it attitudinal change where the focus is on motivation to learn and change and the confidence to do so</td>
</tr>
<tr>
<td></td>
<td>• Is it psychomotor and behavioural change where the focus is on the physical and mental skills and the habits and routines to make the suggested changes</td>
</tr>
<tr>
<td>What do patients want to learn</td>
<td>The physiotherapist should base their education strategies on the needs of the individual:</td>
</tr>
<tr>
<td></td>
<td>• Priorities should be set about what to teach in the time available</td>
</tr>
<tr>
<td></td>
<td>• Written information can be used for lower priority topics</td>
</tr>
</tbody>
</table>

Table 6.8: Effective teaching and learning strategies (Hammond & Niedermann, 2010)

A needs assessment can be undertaken formally or informally. A formal assessment can involve the use of an information questionnaire (Kiesler & Auerbach, 2006). Whilst tools are available for some problems (Rees, Abed, & Sheard, 2003), I am unaware of an equivalent for LBP. I therefore suggest that the most practical option is the use of open-ended questions to determine what the patient knows about their back pain, and what they would like to know. The following questions demonstrate respect for the patient’s autonomy and enable the physiotherapist to tailor their educational strategies effectively:

- how much do you know about back pain?
- would you like to know more about the current guidelines for back pain?
- would you like to learn some exercises to help you control your symptoms?
Supplementing the provision of information by regular checks that the patient understands the information can identify areas that require clarification (Hammond & Niedermann, 2010).

**ii. Learning theory**

An awareness of learning theory can enhance the ability of clinicians to provide effective education (Coates, 1999:50). It can assist them in recognising that patients’ differ in their learning needs and readiness to learn and that such differences will influence the outcome of the encounter (Cross, Moore, Morris, Caladine, Hilton, & Bristow, 2006:70). Three broad categories of learning theory have been identified:

- behaviourism which emphasises instructional objectives, the focus is on the teacher;
- cognitive psychology which emphasises the contextualisation of the information, the focus is more towards the learner;
- humanistic which emphasises the resources of the learners and as such is learner-centred (Cross et al., 2006:73; Hulse, 1997)

Patients are a diverse group who will vary in their ability, experience, personalities and preferred learning style. In attempting to engage their patients in a working alliance, physiotherapists will have to adopt a variety of different approaches depending on the individual patient. How can awareness of this concept be raised? Once again my perception is that educational institutions have a key role, particularly in the undergraduate curriculum. Additionally, my university regularly runs clinical educator days for therapists involved in supervision of students. These provide an ideal opportunity to cover aspects of learning theory so mentors can support the students. The university also runs postgraduate courses in the facilitation of education; however these are only attended by therapists with a particular interest in mentoring and supervision.

**iii. Learning styles**

It is suggested that teaching should be adapted to suit an individual’s preferred learning style (Hammond & Niedermann, 2010). The concept of learning styles has attracted considerable attention since its origins in the psychology literature in the
1950’s. It is based on the concept that the way that people approach a learning situation affects how much they benefit from it. There is a considerable variety of terminology in the literature. Broadly the concept can be categorised into three:

- cognitive style - the psychological processes of perception, thinking, memory and learning;
- learning style – the way in which information is processed;
- learning strategies and learning/instructional preferences – the preferences for one type of learning environment over another.

An individual’s cognitive style can be viewed as the innermost layer of an “onion”. It is considered to be “an in-built and preferred way in which an individual responds to situations and data” and hence relatively consistent (Cuthbert, 2005:236). An individual’s learning style is also consistent but can be influenced by external factors. Learning strategies are the outermost layer of the “onion” and are the most accessible and least stable of the three constructs. A number of questionnaires and inventories have been developed to assess an individual’s preferred learning styles and strategies. The most well known model is that of Kolb (Smith, 2001b) who proposed four learning styles: converger, diverger, assimilator and accommodator. This was adapted by Honey and Mumford to categorise individuals into reflectors, activists, pragmatists or theorists (www.Campaign for learning). Another commonly used categorisation is the VARK. This system proposes that information is received through different routes and categorises individuals according to their preferred preference (visual, aural, reading, kinaesthetic or multimodal) (www.VARK).

Whilst the use of learning styles for physiotherapists is intuitively appealing, the concept is not without issues. In a large review of 13 models of learning styles, Coffield et al., (2004) found considerable variation between the models in terms of quality. In addition the associated measurement instruments demonstrated poor reliability and validity. Overall the authors concluded that research into the concept was inconclusive. My perception is that the most promising aspect of learning styles for physiotherapists is in increasing awareness of their own preferred style and that of their patients. It may be that perceived non-compliance or lack of motivation reflects a clash of learning styles rather than a difficult or truculent patient.
Whilst this section has focused on strategies to enhance education, it is closely linked with *Identifying and addressing psychosocial factors* (Section 6.2). A thorough exploration of the patient’s belief system and experience of their back problem can mean that educational strategies are more effective. It was evident in the findings that frequently the participants and patients understanding of back pain were different. A limited exploration of such beliefs may impede the learning process (Lamiani & Furey, 2009).

### 6.5 Facilitating self-management

The participants in the study identified self-management as their goal of physiotherapy (Section 5.2.3). Consequently their endeavours were focused on engaging the patient in this aim. It is suggested that for self-management to be effective, it should focus on the needs of the individual rather than simply on the provision of advice (Klaber Moffett, 2002). As discussed in relation to *Reconciling perspectives* (Section 5.3.6), the term education is associated with behaviour change and not just enhancing knowledge. To this end it is suggested that physiotherapists should draw on theoretical models to enhance their skills in designing effective educational strategies (Hammond & Niedermann, 2010; Klaber Moffett, 2002).

**Implication 6:**
Physiotherapists should utilise relevant psychological models to enhance their skills in facilitating self-management

The use of cognitive behavioural therapy (CBT) interventions which focus more on psychosocial influences on pain have received interest in recent years. The cognitive behaviour model proposes a cycle whereby the way an individual thinks about their problem influences their emotions, which directs their behaviour, which unintentionally maintains the thoughts. CBT interventions aim to break the cycle by the use of interventions to change behaviours and beliefs (Hansen, Daykin, & Lamb, 2010). Their adoption by physiotherapists has been recommended to enhance outcomes (Harding & Williams, 1995). As discussed in Section 5.2.5 studies that have investigated this approach have reported mixed results. This may be due in
part to the structure of a CBT programme and its delivery by physiotherapists. The programme typically consists of an initial individual assessment, which can last up to 90 minutes, followed by group sessions (Hansen et al., 2010). This format is quite different to the current format of out-patient musculoskeletal physiotherapy appointments. Concern has also been expressed that physiotherapists may find it challenging to consider psychosocial factors before physical factors and that additional training may be required (Moffett 2005). This is supported by Daykin and Richardson (2004). In considering this issue, I was concerned to explore psychological models that can easily be integrated into current practice and would not require lengthy training. The use of a modified version of the Health Action Process Approach has already been proposed to facilitate goal-setting. In addition I suggest the adoption of two social cognitive models to facilitate self-management. These are:

- Self-efficacy component of social cognitive theory
- The transtheoretical model

6.5.1 Suggestions for practice

i. Self-efficacy component of social cognitive theory

Self-efficacy has been referred to in relation to acceptance of pain by the patient (Section 5.5.4). There is considerable evidence that self-efficacy plays an important role in mediating the relationship between pain and disability (Asghari & Nicholas, 2001; Denison et al., 2004; Woby et al., 2007b). In addition, Taal et al., (1996 231) considered that self-efficacy is a significant factor in influencing self-management behaviour as this involves a “constant process of making behavioural choices and decisions”. A greater appreciation of the theoretical underpinning of self-efficacy appears to be warranted.

Central to Bandura’s social cognitive (also termed social learning) theory (1977) are the concepts of efficacy and outcome expectations. Efficacy expectations refer to a person’s confidence in their ability to successfully perform a particular activity, while outcome expectations refer to judgements about whether the change will lead to a valued outcome (Figure 6.4). Bandura (1977) differentiated between the two suggesting that an individual may believe that a behaviour will result in a certain
outcome, however if they doubt their ability to carry out the required actions, the belief will not influence their behaviour.

Figure 6.4: Efficacy and outcome expectations (Bandura, 1977)

In terms of relating the concept of self-efficacy to physiotherapy practice, there are two approaches. The first involves an evaluation of an individual patient’s self-efficacy, whilst the second relates to measures by which it can be strengthened. A suggestion for the former is functional sub-scale of the Chronic Pain Self-Efficacy Scale (CPSS), originally devised by Anderson et al., (1995) and slightly modified by Woby, Urmston et al., (2007b) (Table 6.9). The responses are marked on a nine-point Likert scale where 0 = totally unconfident, 4 = moderately confident and 8 = totally confident. The scores range from 0-72 with higher scores indicating greater functional self-efficacy. Whilst Woby, Urmston et al., (2007b) suggest that the scale demonstrates good internal consistency and test-retest reliability; they do not provide a cut-off score below which concerns should be raised regarding the patient’s self-efficacy.

Table 6.9: Self-efficacy for physical function (Woby et al., 2007b)

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How certain are you that you can walk half a mile on a flat surface?</td>
</tr>
<tr>
<td>2</td>
<td>How certain are you that you can lift a 10 pound box?</td>
</tr>
<tr>
<td>3</td>
<td>How certain are you that you can perform a daily home exercise programme?</td>
</tr>
<tr>
<td>4</td>
<td>How certain are you that you can perform your household chores?</td>
</tr>
<tr>
<td>5</td>
<td>How certain are you that you can shop for groceries or clothes?</td>
</tr>
<tr>
<td>6</td>
<td>How certain are you that you can engage in social activities?</td>
</tr>
<tr>
<td>7</td>
<td>How certain are you that you can engage in hobbies or recreational activities?</td>
</tr>
<tr>
<td>8</td>
<td>How certain are you that you can engage in family activities?</td>
</tr>
<tr>
<td>9</td>
<td>How certain are you that you can perform the work (household) duties you had prior to the onset of chronic pain?</td>
</tr>
</tbody>
</table>
Four factors have been identified as influencing self-efficacy: performance accomplishment; vicarious experience; verbal persuasion and physiological state (Bandura, 1977). The factors are detailed in Table 6.10 in conjunction with their implications for physiotherapy. Whilst persuasive communication is recognised as the most common method for patient education, it is suggested that this is most effective when used in combination with other methods.

<table>
<thead>
<tr>
<th>Influence</th>
<th>Detail</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance accomplishment</td>
<td>Successful performance of a task will increase self-efficacy</td>
<td>• Tasks should be broken up into small manageable ones</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Goals should be realistic and attainable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Goals should gradually increase in complexity and difficulty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Positive feedback should be provided</td>
</tr>
<tr>
<td>Vicarious experience</td>
<td>Seeing others achieve is likely to generate an expectation of self</td>
<td>• Groups should consist of patients with similar characteristics (live modelling)</td>
</tr>
<tr>
<td></td>
<td>achievement</td>
<td>• Individually patients can be informed about patients with similar problems and how they were successful (symbolic modelling)</td>
</tr>
<tr>
<td>Persuasive communication</td>
<td>Provision of advice, suggestions and instructions to convince patients</td>
<td>• Patients should be stimulated to gradually set more challenging goals</td>
</tr>
<tr>
<td></td>
<td>they have the ability to attain goals</td>
<td></td>
</tr>
<tr>
<td>Physiological state</td>
<td>Physiological responses to exercise are interpreted as signs of</td>
<td>• Assist patients to re-interpret physiological signs</td>
</tr>
<tr>
<td></td>
<td>worsening symptoms</td>
<td></td>
</tr>
</tbody>
</table>

Table 6.10: Influences on self-efficacy – implications for musculoskeletal physiotherapy (Bandura, 1977)

Two recent studies raise additional pertinent issues regarding the role of the physiotherapist in enhancing self-management for patients. In a study of patients’ perceptions of self-management, Cooper et al., (2009) found that the majority of strategies adopted by the patients were self-taught. The authors suggested that physiotherapists may need to broaden their repertoire of teaching to include the
facilitation of personal goal-setting, the incorporation of problem-solving techniques and the reviewing of action plans.

Additionally, the concept of “responsibility attribution” is proposed as an under-developed influencing factor (Audulv, Asplund, & Norbergh, 2010). It is suggested that responsibility for the management of a condition can be accredited to a number of sources including health-care practitioners, family or employers. In a qualitative study of individuals living with chronic problems, which did not include musculoskeletal dysfunction, it was found that participants either assumed responsibility for self-management, attributed responsibility to other people or factors or demonstrated a combination of the two (Audulv et al., 2010). The authors suggested that this has implications for health-care professionals who need to be sensitive to the requirements of individual patients. Whilst a link is not overtly drawn between this concept and that of “locus of Control” (Rotter, 1975), my perception is that the concepts are similar. Interestingly “Health Locus of Control” (Wallston, Wallston, Kaplan, & Maides, 1976) has not been found to be a strong indicator of subsequent health behaviour (Hammond & Niedermann, 2010).

ii. Transtheoretical model
The Transtheoretical Model (TTM) has been proposed a useful theoretical model to explain the differences in success during treatment for a range of psychological and physical health problems. It was originally developed to facilitate an understanding of the cessation of addictive behaviours (Prochaska & DiClemente, 1983). Since then it has been a topic of considerable interest (Littell & Girvin, 2002). A recognition that initiating physical activity can be conceptualised as the cessation of a sedentary lifestyle has resulted in its application to health-promoting activities such as physical exercise (Marcus & Simkin, 1994). The key constructs include:

- stages of change;
- processes of change;
- decisional balance;
- self-efficacy;
- temptation (Kerns & Habib, 2004).
The stages of change construct is considered integral to the model and hence the TTM model is frequently termed the stages of change model. Stages of change (Figure 6.5) proposes that individuals progress through five stages when attempting to modify a certain behaviour and that they vary in terms of their readiness to make a change (Kerns & Habib, 2004). It is recognised however that individuals often make several attempts at changing their behaviour and that they may relapse and move back through the stages (Marcus & Simkin, 1994). Processes of change are the strategies that individual’s use when moving from one stage to the next. It is suggested that in stages 1-3 cognitive and affective strategies are important, whilst in stages 4-5 behavioural activities should be emphasised (Hammond & Niedermann, 2010). Decisional balance relates to two main factors – the pros and cons of a specific behaviour (Marcus & Simkin, 1994).

**Figure 6.5: Stages of Change (adapted from Prochaska & DiClemente, 1983)**

The TTM is intuitively appealing as matching interventions to the patient’s stage of change has the potential to enhance their effectiveness. The model has been applied to facilitating physical activity and the self-management of chronic pain. In terms of the former, it appears that results are mixed. Whilst Marcus and Simkin, (1994) suggest that it can provide a useful guide for exercise behaviour interventions, Basler, Bertalanffy, Quint, Wilke and Wolf (2007) found that a short
TTM-based motivation programme was not superior to a placebo in terms of time spent in physical activity in a group of elderly patients with chronic LBP. In an extensive critique of stages of change, Little and Girvin (2002) questioned its validity. They found that the stages are not mutually exclusive and that there is limited evidence of chronological movement through them in studies of specific problem behaviours.

The TTM has also been applied to facilitate an understanding of how a self-management approach to chronic pain may be enhanced. It is suggested that individuals with chronic pain vary in their readiness to adopt a self-management approach. Consequently the development of an instrument to assess the stage of readiness has proved a topic of some interest. The development and initial validation of the Pain Stages of Change Questionnaire (PSOCQ) was described by Kerns Rosenberg, Jamison, Caudill and Haythornwaite (1997). The questionnaire has been the subject of additional studies to determine its psychometric properties (Jensen, Nielsen, Romano, Hill, & Turner, 2000) and predictive value for engagement and outcomes in a treatment programme (Kerns & Rosenberg, 2000). Overall, the studies indicate that whilst the questionnaire demonstrates internal consistency, its clinical utility is questionable in the presence of complex and multifactorial chronic pain problems.

It is evident that work in this area is on-going. More recently Zenker et al., (2006:426) demonstrated the potential of the German version of the PSOCQ (the Freiburg Questionnaire-Stages of Chronic Pain Management) to classify patients with chronic LBP. They suggested that patients who commence an intervention “at least partly convinced that managing pain is their responsibility” have superior outcomes to patients who continue to rely on the medical profession to manage their problems. Despite the limited evidence for its use, the TTM remains a popular and clinically appealing model. Hammond and Niedermann (2010:83) did not consider the lack of evidence for it efficacy, instead they suggested that it has several implications for patient education (Table 6.11).
• Not all patients are ready for change
• Patients who are ready may not be in the same stage
• Individualised interventions are required
• Patients who fail to participate may be in stages 1 and 2
• For these patients it is important to enhance motivation and reinforce the benefits of change
• Stage 3 requires the provision of action plans and practical advice to enhance self-efficacy and address the cons
• Stage 4 requires action and self-efficacy to be supported through the use of diaries, cues to action and rewards
• Stage 5 requires strategies to address the prevention of relapses such as the identification of risk situations
• Physiotherapists should be aware of the long-term perspective of behavioural changes

Table 6.11: Clinical implications of the TTM

My own perception reflects that of Hammond and Niedermann (2010). It was evident in my study that the participants experienced a number of issues in attempting to engage their patients in a working alliance (section 5.5.4). An awareness of the TTM has the potential to enhance their ability to manage discrepancies and non-engagement. A concern is the lack of a simple and easily administered questionnaire. Reducing the PSOCQ to a few additional questions in the subjective interview appears simplistic. However, the participants appeared perceptive to their patients and it maybe that an awareness of the TTM is sufficient to heighten awareness of potential issues.

The concepts of self-efficacy and the transtheoretical model have already started to appear in undergraduate texts (e.g. Hammond & Niedermann, 2010). Consequently it is likely that an awareness of their relevance to practice will increase. For qualified physiotherapists, educational institutions have a role in introducing the concepts in their modules and short courses. In my own institution a number of modules already highlight their potential value in relation to clinical reasoning and rehabilitation.

6.6 Enhancing communication

Effective communication skills have been highlighted as key to *Engaging the patient* (Section 5.5.5). Whilst a number of studies have recommended that the communication skills of physiotherapists should be enhanced, it is also evident that training in this aspect of their professional care may not be perceived as necessary.
There is a paucity of training courses that address communication skills for qualified physiotherapists and anecdotally colleagues confirm that such courses are not appealing. The problem may stem from the undergraduate curriculum. As a result of a questionnaire survey of the teaching of communication in qualifying programmes in the UK, Parry and Brown (2009) proposed a number of improvements. However they also recognised that teaching in this area is challenging in terms of expertise and resources. In my study, the participants acknowledged the value of their experience in engaging their patients. However it is recognised that communication is a series of learned skills and that “experience is a poor teacher: it needs observation plus well intentioned, constructive, detailed and descriptive feedback plus rehearsal to effect change” (www.Skillscascade). Role play and audio or video recording have been suggested as useful strategies to enhance the assessment skills of physiotherapists (Goldingay, 2006a:83). In my own University one of the postgraduate modules used video-recordings of role play for problem scenarios identified by the students. Whilst this session was illuminating and informative for the students, it is unlikely that this approach could be implemented on a large scale. The problem remains of how to engage physiotherapists in communication skills training. A potential way forward lies in the strategy of motivational interviewing. This was identified in relation to acceptance of pain by the patient (Section 5.5.4).

Implication 7: Physiotherapists should explore the use of motivational interviewing techniques to enhance their communication skills

6.6.1 Suggestions for practice

Whilst the efficacy of stages of change in isolation appears to be questionable, motivational interviewing (MI) has attracted more support. MI is a communication approach that assists health professionals to facilitate their patients to change their behaviour (Flinn & Jones, 2010). The approach conceptualises motivation not as a stable characteristic of personality, but as state of readiness, which is open to change (Britt, Hudson, & Blampied, 2004). Although described as patient-centred, MI is also directive. Behaviour change is the goal and a number of strategies and
techniques are employed to achieve this (Britt et al., 2004). Initially MI drew on a number of concepts within social psychology, but later it was linked to the TTM, in particular stages of change. It is suggested that MI is particularly effective for patients who are in the precontemplation or contemplation phases of readiness to change (Flinn & Jones, 2010). The approach is consistent with a number of health behaviour models including Social Cognitive Theory and The Health Action Process Approach (Britt et al., 2004). The advantages and disadvantages of the approach are outlined in Table 6.12. The principles of MI include:

- expressing empathy;
- developing discrepancy;
- avoiding argumentation;
- rolling with resistance;
- supporting self efficacy (Lawn & Schoo, 2010).

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training is available for professionals</td>
<td>Effective implementation requires extensive training</td>
</tr>
<tr>
<td>The approach is flexible and can be applied in many health settings</td>
<td>The approach follows a process – but provides little formal structure</td>
</tr>
<tr>
<td>The approach suits many patients with chronic diseases</td>
<td></td>
</tr>
<tr>
<td>It can be used in lengthy and short consultations</td>
<td></td>
</tr>
<tr>
<td>It is well suited to support ongoing self-management and behavioural change</td>
<td>Health professionals may underestimate the complexity of the approach</td>
</tr>
<tr>
<td>Clinical trials have demonstrated the effectiveness of the approach</td>
<td>Effectiveness is subject to the quality of training and ongoing supervision</td>
</tr>
</tbody>
</table>

Table 6.12: The advantages and disadvantages of Motivational interviewing (Britt et al., 2004)

Central to MI is the recognition, exploration and resolution of a patient’s ambivalence to change. Key to this is the communication between the healthcare professional and the patient. Shannon and Hillsdon (2007) illustrated the process with the example of a patient with back pain who is considering the adoption of a structured exercise programme. Whilst the benefits of exercise are motivational, the patient may have anxieties about the disadvantages. If the healthcare professional stresses the importance of change they are likely to encounter resistance. Instead, discrepancy is developed. The patient is encouraged to express their own reasons as to why the
change will be beneficial. “The aim of MI is to develop the discrepancy until it becomes so great that it outweighs the perceived benefits of the status quo” (Shannon & Hillsdon, 2007:209).

MI has been advocated for the management of musculoskeletal and orthopaedic problems and it was found to be one of the most common approaches to enhancing self-management in Australia (Lawn & Schoo, 2010). Whilst MI is clearly applicable to the management of LBP it also has a number of limitations (Table 6.12). “Pure” MI involves a series of lengthy sessions with psychologists and skilled counsellors who have undertaken additional training (Resnicow, Dilorio, Soet JE, Borrelli, Ernst, Hecht, & Thevos, 2002:253). For such professionals, the techniques of MI serve to enhance and refine their skills. In contrast, for healthcare professionals without this background MI may “represent a total retooling of their orientation”. They are challenged with adopting a more facilitative and collaborative approach in place of the typically instructional and prescriptive orientation of the biomedical model. Additionally it is suggested that limited time for training and supervision can make it difficult for some healthcare professionals to become proficient in the approach (Resnicow et al., 2002:255). In response to these issues, the principles of MI have been adapted to meet the needs of different settings. These include the Drinkers Check Up (DCU), Motivational Enhancement Therapy (MET) and Brief Motivational Interviewing (BMI). These variations have been termed Adaptations of MI (AMI) and indeed it is suggested that the majority of studies of MI have in fact utilised AMI (Burke, Arkowitz, & Dunn, 2002:218).

The efficacy of MI has been demonstrated in a range of addictive behaviours; however there are few studies that have explored its use in health problems (Britt et al., 2004). One exception is a recent study by Vong, Cheing, Chan, So and Chetwyn (2011) which demonstrated promising results. In the study, the intervention group receiving MET combined with interferential for pain relief, demonstrated significantly better results on a range of outcome measures including motivation, compliance and physical function over a control group. Unfortunately the intervention strategy is not documented making it difficult for physiotherapists to easily incorporate the techniques into their practice. Criticisms notwithstanding, it appears that MI and AMI techniques appear to be useful for enhancing patient engagement in a working
alliance. They could potentially limit situations of persistent non-engagement and/or equip physiotherapists with the skills to manage such situations more effectively.

In a review of MI and its adaptations, Rollnick et al., (2002) suggested that the methods are in reality very similar. They share the goal of eliciting motivation to change and collaboration carried out in a non-confrontational manner. The authors identified three different types of behaviour change interventions: brief advice, behaviour change counselling and MI which appear to be on a continuum (Table 6.13). The three are differentiated by the context, goals and the skill of the professional. In relating the interventions to current physiotherapy practice, my perception is that whilst it is most closely aligned to Brief Advice, a shift towards Behaviour Change Counselling would enhance the communication skills of physiotherapists. Such a transition is challenging. Details of the AMI interventions are not easily accessible and although courses are available, they tend to be relatively short with no ongoing provision for support.

Miller and Rollnick (2002:33) distinguish between the “spirit” and “techniques” of MI. The former is associated with collaboration, evocation (the recognition that the resources for motivation and change reside within the patient) and patient autonomy. It may be that the techniques are less of an issue than embracing the philosophy. I have found the motivational interviewing website a particularly useful resource (www.motivationalinterview). It provides practical advice and strategies including an example of an MI session and questions that can be utilised to evoke change. In terms of implementation, my university is planning to offer a short course on the use of MI in the management of long term conditions. The extent to which physiotherapists whose practice is characterised by a model of professionally driven best interest compromise can embrace such a profound change in perspective remains to be seen.
<table>
<thead>
<tr>
<th></th>
<th>Brief advice</th>
<th><strong>Behaviour change counselling</strong></th>
<th><strong>MI</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session time</td>
<td>5-15 minutes</td>
<td>5-30 minutes</td>
<td>30-60 minutes</td>
</tr>
<tr>
<td>Setting</td>
<td>Mostly opportunistic</td>
<td>Opportunistic or help-seeking</td>
<td>Mostly help-seeking</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate respect</td>
<td></td>
<td>Establish a rapport</td>
<td></td>
</tr>
<tr>
<td>Communicate risk</td>
<td></td>
<td>Identify client goals</td>
<td></td>
</tr>
<tr>
<td>Provide information</td>
<td></td>
<td>Exchange information</td>
<td></td>
</tr>
<tr>
<td>Initiate thinking about change in problem behaviour</td>
<td></td>
<td>Choose strategies based on client readiness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Build motivation for change</td>
<td></td>
</tr>
<tr>
<td>Plus:</td>
<td></td>
<td>Plus:</td>
<td></td>
</tr>
<tr>
<td>Establish a rapport</td>
<td></td>
<td>Develop relationship</td>
<td></td>
</tr>
<tr>
<td>Identify client goals</td>
<td></td>
<td>Resolve ambivalence</td>
<td></td>
</tr>
<tr>
<td>Exchange information</td>
<td></td>
<td>Develop discrepancy</td>
<td></td>
</tr>
<tr>
<td>Choose strategies based on client readiness</td>
<td></td>
<td>Elicit commitment to change</td>
<td></td>
</tr>
<tr>
<td>Build motivation for change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Style</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner-recipient</td>
<td>Active expert-passive recipient</td>
<td>Counsellor–active participant</td>
<td>Leading partner-partner</td>
</tr>
<tr>
<td>Confrontational – challenging</td>
<td>Sometimes</td>
<td>Seldom</td>
<td></td>
</tr>
<tr>
<td>Empathetic</td>
<td>Sometimes</td>
<td>Usually</td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>Provided</td>
<td>Exchanged</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6.13: Behaviour change interventions (Rollnick et al., 2002)

6.7 Summary of the implications for practice

The implications of the findings have been considered under five broad headings and suggestions for practice have been proposed (Table 6.14). It is evident that I consider that universities have a key role in implementing the suggestions I have
made in response to the findings of the study. This undoubtedly reflects my own role in higher education. There are two further issues to consider in relation to the implications. The first relates to organisational culture and the second to the management of LBP. In terms of the former, the participants indicated that despite the constraints on their practice, as a department they strived to place the patient at the centre of their care (Section 5.5.6). The considerable influence of contextual factors was illustrated by Aita, McIlvain, Backer, McVea and Crabtree (2005). The researchers explored PCC and communication in primary care in the United States. They found that in addition to the influence of the individual physician and patient, the interaction between them was influenced by the culture of the individual practice and community in which they operated. It is apparent that individual physiotherapy departments and Trusts clearly play a key role in promoting the ethos of PCC. Finally, the uncertainties and ambiguity surrounding the management of LBP have been highlighted as a considerable issue for physiotherapists in terms of engaging their patients. The situation is exacerbated by the lack of consistency in the messages received by patients. This will only be resolved when there is a national consensus regarding the appropriate management of the problem. Whilst the forthcoming decisional aid may be helpful (Section 6.3.2), at present it is unlikely that the situation will see any dramatic changes.

6.8 Contribution to knowledge

This study explored the meaning of PCC from the perspective of physiotherapists, the first study to specifically address this issue. The concept of PCC provided a springboard for a deeper exploration of what it means to be a physiotherapist. The wealth of rich data from the interviews provides an insight into current musculoskeletal out-patient practice within the NHS from the perspective of the participants. The contribution of the study to current knowledge regarding contemporary physiotherapy practice is considered under three headings:

- the concept of PCC within physiotherapy;
- the theoretical foundation PCC;
- empirical support.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Implications</th>
<th>Suggestions for practice</th>
<th>Key players:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Identifying and addressing psychosocial factors</td>
<td>1. Physiotherapists should recognise the considerable influence of the patient’s belief system upon the outcome of physiotherapy</td>
<td>• Implement a pre-treatment package</td>
<td>Individual physiotherapist, Organisation, CSP, Universities</td>
</tr>
<tr>
<td></td>
<td>2. Physiotherapists should attend to the patient’s experience of pain in the context of their everyday life</td>
<td>• Incorporate additional questions into the subjective assessment</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2 Facilitating the decision-making process</td>
<td>3. An appreciation of the theoretical basis of goal-setting may enhance the ability of physiotherapists to engage their patients in a working alliance</td>
<td>• Integrate a theoretical framework for goal-setting</td>
<td>Individual physiotherapist, Universities</td>
</tr>
<tr>
<td></td>
<td>4. Physiotherapists have to strike a balance between therapist-led and partnership approaches to decision-making</td>
<td>• Be sensitive to the needs and preferences of individual patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Establishing a conducive learning environment</td>
<td>5. Physiotherapists should tailor education according to the needs of an individual patient</td>
<td>• Assess the individual needs of the patient</td>
<td>Individual physiotherapist, Universities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Be sensitive to the potential for differing learning styles</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4 Facilitating self-management</td>
<td>6. Physiotherapists should utilise relevant psychological models to enhance their skills in facilitating self-management</td>
<td>• Consider strategies to enhance self-efficacy</td>
<td>Individual physiotherapist, Universities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognise that patients may be in differing stages in their readiness to adopt a self-management approach</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Enhancing communication</td>
<td>7. Physiotherapists should explore the use of motivational interviewing techniques to enhance their communication skills</td>
<td>• Acknowledge the philosophy of motivational interviewing and consider the integration of its “spirit” and/or techniques into practice</td>
<td>Individual physiotherapist, Universities</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Table 6.14: The implications of the findings for practice
6.8.1  The concept of patient-centred care within physiotherapy

This study was stimulated by the challenge to physiotherapists to explore the meaning of PCC in a physiotherapeutic context (Blackledge, 2005). The findings have been theoretically conceptualised into a processual journey of engaging the patient in a working alliance. The process consists of three interrelated and mutually dependent categories of interpreting the problem, reconciling perspectives and developing an alliance. Whilst the process bears some resemblance to models developed in medicine; there are also some fundamental differences. These reflect the characteristics, roles and philosophies of the individual professions. My perception is that this is the first representation of PCC within musculoskeletal physiotherapy from the perspective of physiotherapists themselves.

6.8.2  The theoretical foundation of patient-centred care

The process of engaging the patient has been explored to illuminate its theoretical foundation. Drawing on a number of different disciplines and philosophies, it is proposed to be underpinned by three main concepts: complex responsive process of relating; physiotherapeutic use of self and strategic action. Siegert and Taylor (2004) have argued that rehabilitation requires a theoretical basis if it is to progress as a discipline. My perception is that the proposed model may serve to heighten awareness of the mainly intuitive processes adopted by physiotherapists, inform the development of interventions and form the basis for further research.

6.8.3  Empirical support for a proposed framework for education

Taal, Rasker and Wiegman (1996) proposed criteria for the development and evaluation of educational self-management programmes based on standards set for education of patients with arthritis in the United States and self-efficacy theory (Table 6.15). The criteria were supported by Coates (1999:165) and more recently by Hammond and Niedermann (2010:79). Although developed independently, the similarities between the criteria and the implications of my findings (Table 6.14) are clearly evident. The findings therefore provide empirical support for the principles proposed by Taal et al., (1996). As such they have the potential to provide a useful tool to influence and modify or develop new and existing intervention strategies.
<table>
<thead>
<tr>
<th>Step</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>A thorough problem analysis</td>
</tr>
<tr>
<td>Step 2</td>
<td>Utilise a theoretical model</td>
</tr>
<tr>
<td>Step 3</td>
<td>Influence knowledge, behaviour and health status</td>
</tr>
<tr>
<td>Step 4</td>
<td>Teach effective self-management skills</td>
</tr>
<tr>
<td>Step 5</td>
<td>Utilise effective methods of teaching self-management skills and strengthening self-efficacy</td>
</tr>
<tr>
<td>Step 6</td>
<td>Involve people from the person’s social environment</td>
</tr>
<tr>
<td>Step 7</td>
<td>Evaluate the effectiveness of the programme</td>
</tr>
</tbody>
</table>

Table 6.15: 7 step approach to the development and evaluation of an educational self-management programme (Taal et al., 1996).

The implications of the findings have been considered in detail. A number of suggestions have been made as to how the findings could potentially enhance the practice of musculoskeletal physiotherapists. However, these suggestions have to be considered in light of the limitations and strengths of the study.

6.9 Limitations and strengths of the study

The limitations and strengths of the study are considered in relation to the criteria of “trustworthiness”: credibility; transferability; dependability and confirmability (Section 4.8) and the factors that impact upon the quality of a grounded theory study: researcher expertise; methodological congruence and procedural precision (Section 3.5)

6.9.1 Limitations of the study

The limitations of the study can be considered in relation to my choice of method, the sample of physiotherapists I selected for the study and my own expertise as the researcher.

Interviews were selected as the method of data collection as I considered that they were congruent with my philosophical stance for the study. Interviews do however have their limitations as a form of data collection. They are specific to the context in which they are undertaken and can be perceived as “invented, if you will, to fit the demands of the interactive context of the interview, and representative of nothing
more or less” (Miller and Glassner 2004:125). Additionally, the language adopted by interviewees, and indeed the researcher, can serve to limit the extent to which an insight into subjective perceptions can be attained. Another consideration is that I was seeking the views of the participants and not observing a patient-therapist interaction. In the latter, the participant has to take into account the actions of the patient and “fit” their line of activity in response to the actions of the patient (Blumer, 1969:8). What the participants have said may not necessarily reflect the reality of the patient-therapist interaction. Despite their limitations, Miller and Glassner (2004:126) suggest that knowledge of the social world beyond the interaction can be obtained through qualitative interviewing.

The study was undertaken in a single Trust which is located on the outskirts of London. All the participants worked in the same Physiotherapy department and indeed a number of them had been employed there for a number of years. Consequently it is inevitable that their perceptions of patient-centred care would have been influenced by their professional socialisation (Section 5.5.5) and the culture of the department (Section 6.7). It also has to be considered that a number of staff who met the inclusion criteria did not volunteer to participate. It is not possible to determine whether the views of the participants differed from those who chose not to contribute to the study. In evaluating the trustworthiness of qualitative research, the term transferability refers to the extent to which the findings of a study can be applied to other settings. In this study the details of the participants have been provided, along with the context in which it occurred. It is anticipated that this will provide the reader with sufficient detail to enable them to consider the findings in the light of their own practice.

I began the study as a novice in GT. My inexperience was most evident when it came to analysing the data (Section 4.10.2). I struggled with the differences between a code, concept, category and sub-category and the intricacies of axial and selective coding. Despite recognising the pitfalls associated with the methodology, I still failed to avoid some of them. However, acknowledging my limitations meant that I was very diligent during this process. I constantly returned to the raw data to ensure my emerging categories were “grounded”. My confidence grew as the theory emerged and I felt comfortable that I was not forcing the data into pre-conceived categories.
6.9.2 **Strengths of the study**

Birks and Mills (2011:147) have suggested that the quality of a GT study can be determined by the quality of the data and the application of GT methods. They proposed a set of criteria to assist in the evaluation of GT research and I found it useful to apply these to my study (Birks & Mills, 2011:153) (Table 6.16). Whilst my perception is that the answer to the questions is “yes”, this does have to be considered in respect to the limitations of the study.

The credibility of the study was enhanced by full and accurate transcription of the interviews, prolonged immersion in the data analysis and triangulation. Respondent validation ensured that the transcribed data was a correct representation of the interviews. The theory evolved over a long period of time (Section 4.10.2) and at each stage I returned to the data to ensure that I was not misrepresenting it. As discussed in Section 4.10.1, triangulation can take a number of formats. In this study, it involved the convergence of different perspectives. Two experienced researchers supervised the study and their guidance was invaluable in ensuring that the emerging themes were robust. Finally, the categories are illustrated extensively with direct quotes. This enables the reader to affirm the adequacy and accuracy of my interpretations. The dependability of the study was also enhanced through respondent validation and triangulation. Additionally throughout the study details of the precise method of data collection, analysis and interpretation have been made explicit. Finally the confirmability of the study was enhanced through the detailed audit trail and my awareness of my own influence on the interpretation of the data. As a result the reader can follow the logic applied to the interpretations and ensure that the conclusions reached are warranted by the data.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Criteria</th>
<th>Yes/no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher expertise</td>
<td>Does the researcher demonstrate skills in scholarly writing?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Is there evidence that the researcher is familiar with GT methods?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Has the researcher accessed and presented citations of relevant methodological resources?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Are the limitations in the study design and research process acknowledged and addressed where possible?</td>
<td>Yes</td>
</tr>
<tr>
<td>Methodological congruence</td>
<td>Has the researcher articulated their philosophical position?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Is GT an appropriate research strategy for the stated aims of the study?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Is a GT presented as the end product of the research?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Are philosophical and methodological inconsistencies identified and addressed?</td>
<td>Yes</td>
</tr>
<tr>
<td>Procedural precision</td>
<td>Is there evidence that the researcher has employed memoing in support of the study?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Has the researcher indicated the mechanisms by which an audit trail was maintained?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Are procedures described for the management of data and resources?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Is there evidence that the researcher has applied the essential GT methods appropriately in the context of the study described?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Does the researcher make logical connections between the data and abstractions?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Is there evidence that the theory is grounded in the data?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Is the final theory credible?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Are potential applications examined and explored?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 6.16: Criteria for evaluating grounded theory research (Birks & Mills, 2011:153)

6.10 Recommendations for further research

This study explored the meaning of patient-centred care (PCC) in relation to LBP from the perspective of musculoskeletal physiotherapists. It has culminated in a substantive theory of PCC which revolves around a central process of patient engagement. The theory was developed in response to calls on physiotherapists to define the concept in the context of their own practice. The study is the first to address PCC from the perspective of the clinicians themselves. Grounded theory can be used to either understand, or explain and predict (Section 3.4.4). Whilst the findings have served to clarify the meaning of PCC in relation to the individual
therapeutic encounter, the predictive ability of the theory requires verification from further research. The study only utilised interviews as the method of data collection. Focus groups with musculoskeletal physiotherapists could be used to corroborate the findings. Additionally, the use of observation, either directly or through videoing, would ensure that there was no mismatch between verbal responses and actual practice.

The findings of the study are extensive and a number of additional key areas for exploration were identified:

- The topic of clinical reasoning has attracted considerable interest within physiotherapy. Despite this, it was evident from the study that the interpretation of information from the initial assessment was a largely intuitive process, enhanced by experience. Additional research is required to identify the processes involved so the development of more junior therapists can be facilitated.

- The exploration and management of psychological influences on LBP was identified as challenging for many of the participants. Further studies are warranted to explore and clarify the reasons for this finding.

- The role of the physiotherapist as an educator requires further exploration. It was evident that the participants viewed this aspect of their practice as key to engaging their patients in a working alliance. Whilst several limitations have been identified in this study, these require additional clarification.

- Goal-setting was identified as the process at the heart of engaging the patient. However it was also associated with considerable challenges. Further research is urgently required to develop a more structured theoretical framework for musculoskeletal physiotherapy.

- Maximising patients’ involvement in the decision-making process is a further area for exploration. The professionally driven best interest compromise model is a recent proposition (Sandman & Munthe, 2010). Whilst it appears to reflect the approach of the participants, this requires confirmation.
6.11 Summary of the final discussion

This chapter has considered the implications of the findings of the study to physiotherapy practice. They were considered under the headings of: identifying and addressing psychological factors; facilitating the decision-making process; establishing a conducive learning environment; facilitating self-management and enhancing communication. Seven implications for practice were proposed along with a suggestion of the key players in implementing the suggestions. The contribution of the findings to the knowledge base of physiotherapy have been discussed. The chapter culminated in a review of the strengths and limitations of the study.
Chapter 7
Conclusions

7.1 Introduction

In this chapter, the main findings and recommendations of the study are summarised. The study set out to answer the research question:

What are the perceptions of patient-centred care in contemporary musculoskeletal physiotherapy practice?

The objectives for the study were:

- to explore musculoskeletal physiotherapists’ views of patient-centred care;
- to use the analytical techniques of Grounded Theory (GT) to interpret the data;
- to develop a theory of patient-centred care in the management of LBP by physiotherapists.

7.2 Summary of the findings

Patient-centred care (PCC) has been conceptualised as a process of engaging the patient in a working alliance. It has been proposed to consist of four interrelated and dynamic social interactions:

- interpreting the problem;
- reconciling perspectives;
- developing an alliance;
- engaging the patient.

The final interaction was considered to be the “core category”, the central phenomenon which integrates the other categories.

*Interpreting the problem* was the first stage in the process. Through this process the physiotherapist conceptualised the patient’s problem of back pain into one which was congruent with their own socially constructed meanings. The process of *reconciling perspectives* commenced during *interpreting the problem* and the two interactions then proceeded in tandem. Reconciling perspectives was a vital stage in engaging the patient. Through this interaction the potential existed for the patient and physiotherapist to modify or change their beliefs, attitudes, expectations, decisions and goals. *Developing an alliance* occurred simultaneously with the first two interactions. It was considered that the quality of the alliance had a considerable influence on the
therapeutic process and resulted in a positive experience for the patient. Engaging the patient referred to the extent to which the patient participated in their management programme and was involved in the decision-making process. The participants clearly identified patient self-management as their goal of physiotherapy for low back pain (LBP). Consistent with this view, they perceived that patients had to be involved in their management. To this end considerable effort was invested in “selling the idea” of self-management to their patients. The identification of treatment goals and the involvement of the patient in the decision-making process were key to this process. Successful engagement was perceived to result in a collaborative working alliance; a process unique to the individual patient and physiotherapist.

Theoretical coding was the final phase of the generation of my GT of PCC. Reference to a number of different disciplines and philosophies, enabled me to provide a framework for enhancing the explanatory capacity of the theory. It was proposed that the process of engaging the patient is underpinned by three theoretical concepts:

- complex responsive process of relating (CRPR);
- physiotherapeutic use of self;
- communicative action theory.

As a theoretical framework, CRPR acknowledges the development of self-organising patterns of meaning in social interactions. However it is recognised that this is constrained by certain boundaries. In terms of physiotherapy these could be considered to be the conventions of assessment and the professional remit of the physiotherapist. Reference to counselling theory was considered appropriate due to the centrality of the therapeutic alliance in patient engagement. In theoretical terms, the alliance is explained by a combination of a real relationship, facilitative attributes and the instrumental use of self which I have termed “physiotherapeutic use of self”. Finally, communicative action theory was adopted to explain my perception that professionally driven best interest compromise was the predominant strategy utilised by the participants in terms of decision-making. The final theory represents the first model of PCC in musculoskeletal physiotherapy from the perspective of physiotherapists working in the National Health Service.
7.3  **Summary of the implications for practice**

The implications for practice have been considered in relation to five broad categories:

- Identifying and addressing psychological factors
- Facilitating the decision-making process
- Establishing a conducive learning environment
- Facilitating self-management
- Enhancing communication

As a result, seven implications for practice have been identified:

1. Physiotherapists should recognise the considerable influence of the patient’s belief system upon the outcome of physiotherapy
2. Physiotherapists should attend to the patient’s experience of pain in the context of their everyday life
3. An appreciation of the theoretical basis of goal-setting may enhance the ability of physiotherapists to engage their patients in a working alliance
4. Physiotherapists have to strike a balance between therapist-led and partnership approaches to decision-making
5. Physiotherapists should tailor education according to the needs of an individual patient
6. Physiotherapists should utilise relevant psychological models to enhance their skills in facilitating self-management
7. Physiotherapists should explore the use of motivational interviewing techniques to enhance their communication skills

The key players in implementing the findings were proposed. My perception is that the majority of the responsibility rests with educational institutions both at undergraduate and postgraduate level.

The contribution of the study to current knowledge regarding contemporary physiotherapy practice was also considered. It was suggested that this fell into three main areas:

- the concept of PCC within physiotherapy;
- the theoretical foundation PCC;
- empirical support for a proposed framework of education.
Finally the limitations and strengths of the study were discussed along with recommendations for further research. Whilst the study was relatively small, the depth and richness of the data means that it has provided an insight into what it means to be a physiotherapist operating in the National Health Service at a time of considerable change and uncertainty. PCC remains at the centre of current health care policy (Department of Health, 2010). Consequently the findings of the study have the potential to provide a contribution to knowledge, a topic for discussion and a spring board for further research.

7.4 Grounded theory and physiotherapy

It has been suggested that GT is an appropriate methodology to address questions regarding “complex relationships, clinical situations, or new areas of enquiry” (Resnik Mellion & Moran Torvin, 2002:110). As such it is an ideal approach for many questions within rehabilitation. Additionally, by generating theory, it has been suggested that it has the potential to form the basis for additional research and the implementation of practical innovations (Kennedy & Lingard, 2006). Whilst I am in broad agreement with this premise, I am also cautious in recommending the adoption of GT for studies that are not at doctoral level or undertaken by experienced researchers. The complexity of the methodology is significant and the potential for errors is considerable without adequate experience and / or supervision. My own experience is that the methodology presents a considerable personal challenge. It requires a high level of personal insight, self-discipline and adherence to GT techniques. However it also provides the opportunity for the conduct of rich research (Birks & Mills, 2011:27) which ultimately has the potential to generate theory and influence practice.
References


In J. Higgs, M. Jones, S. Loftus & N. Christensen (Eds.), *Clinical Reasoning in the Health Professions* (3rd ed.). Amsterdam: Butterworth Heinnemann.


Miller, J., & Glassner, B. (2004). The "inside" and the "outside". Finding realities in interviews


[www.workingbacksscotland](http://www.nhsinform.co.uk/health-zones/scottish-backs.aspx) for back pain in Scotland. Retrieved 16th May 2011


## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>A systematic process of information acquisition which guides the subsequent management of the patient's problem. It is broadly divided into a subjective component; an interview, and an objective component; a physical examination.</td>
</tr>
<tr>
<td>Audit trail</td>
<td>A record of decisions made in relation to the conduct of the research.</td>
</tr>
<tr>
<td>Axial coding</td>
<td>The strategy by which the fragmented data are brought back together after initial coding.</td>
</tr>
<tr>
<td>Biomedical</td>
<td>The application of the principles of the natural sciences, especially biology and physiology, to clinical medicine.</td>
</tr>
<tr>
<td>Categories</td>
<td>A higher level of concept that represent a group of concepts.</td>
</tr>
<tr>
<td>Concepts</td>
<td>An idea or notion that encapsulates the characteristics of a phenomenon.</td>
</tr>
<tr>
<td>Conditional matrix</td>
<td>An analytical tool to assist researchers to consider the relationships between micro and macro conditions on each other and the central process.</td>
</tr>
<tr>
<td>Confirmability</td>
<td>All changes in data collection, analysis and interpretation are made explicit throughout the research.</td>
</tr>
<tr>
<td>Constructionism</td>
<td>Epistemological view that all knowledge and therefore all meaningful reality is constructed in and out of the interaction between individuals and their world.</td>
</tr>
<tr>
<td>Constructivism</td>
<td>A form of constructionism which proposes that the construction of meaning occurs within the mind of the individual</td>
</tr>
<tr>
<td>Credibility</td>
<td>The constructed realities of the participants are presented as adequately as possible.</td>
</tr>
<tr>
<td>Critical postmodernism</td>
<td>A combination of critical theory and postmodernism which focuses on exploitative social issues such as inequality and oppression.</td>
</tr>
<tr>
<td>Critical realism</td>
<td>The theory that some of our sense-data can and do accurately represent external objects, properties, and events, while other of our sense-data do not accurately represent any external objects, properties, and events.</td>
</tr>
<tr>
<td>Dependability</td>
<td>All changes in data collection, analysis and interpretation are made explicit throughout the research.</td>
</tr>
<tr>
<td>Diagnostic reasoning</td>
<td>The formation of a diagnosis related to physical disability and impairment.</td>
</tr>
<tr>
<td>Diagnostic triage</td>
<td>A process whereby the history and clinical examination of the patient provide the basis for decisions regarding their subsequent management.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dialectical</td>
<td>A model of reasoning incorporating diagnostic and narrative components</td>
</tr>
<tr>
<td>Dimensions</td>
<td>The range along which the properties of a category vary</td>
</tr>
<tr>
<td>Epistemology</td>
<td>The theory of knowledge; it considers how knowledge of reality may be gained. It can be divided into three forms: objectivism, constructionism and subjectivism.</td>
</tr>
<tr>
<td>Evidence-based practice</td>
<td>The use of current best evidence in making decisions about the care of individual patients</td>
</tr>
<tr>
<td>Gerunds</td>
<td>These are formed by adding “ing” to the noun form of a word. They describe an action, state or process.</td>
</tr>
<tr>
<td>Grounded Theory</td>
<td>A systematic qualitative research methodology which emphasises the generation of theory from data in the process of conducting research.</td>
</tr>
<tr>
<td>Interpretivism</td>
<td>A theoretical perspective underpinned by the epistemological perspective of constructionism which rejects the objective perspective of human knowledge.</td>
</tr>
<tr>
<td>In-vivo codes</td>
<td>The words of the participants are used in the initial coding to preserve their meaning.</td>
</tr>
<tr>
<td>Narrative reasoning</td>
<td>The understanding of patients’ illness experiences, their perspective and beliefs</td>
</tr>
<tr>
<td>Non-specific low back pain</td>
<td>Back pain with in the absence of a specific diagnostic</td>
</tr>
<tr>
<td>Objectivism</td>
<td>Epistemological view that things exist as meaningful entities independent of consciousness and experience.</td>
</tr>
<tr>
<td>Ontology</td>
<td>Assumptions made about the nature of reality</td>
</tr>
<tr>
<td>Paradigm model</td>
<td>An analytical tool devised to assist researchers integrate structure with process.</td>
</tr>
<tr>
<td>Patient-centred clinical method</td>
<td>A model and a clinical method of patient-centred care in medicine</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>A science-based health care profession which emphasises the use of physical approaches in the promotion, maintenance and restoration of an individual's physical, psychological and social well-being and takes into account an individual's variations in health status</td>
</tr>
<tr>
<td>Positivism</td>
<td>A theoretical perspective which argues that the goal of research is objective knowledge gained by a researcher who is an impartial outside observer.</td>
</tr>
<tr>
<td>Properties</td>
<td>Characteristics of a category.</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>This approach integrates the “bio” or medical perspective, with the patient’s perspective including their beliefs about the causes of the pain, their expectations and concerns regarding the future</td>
</tr>
<tr>
<td>Radicular pain</td>
<td>Pain as a result of nerve root compression</td>
</tr>
<tr>
<td>Randomised controlled trial</td>
<td>A type of scientific experiment in which eligible subjects are randomly allocated to receive one or more treatments for the purpose of comparison.</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Red flags</td>
<td>Serious spinal pathology requiring prompt medical attention.</td>
</tr>
<tr>
<td>Reflexivity</td>
<td>The researcher’s scrutiny of their research experience, decisions and interpretations. It allows the reader to determine the extent to which the researcher’s position influenced the findings and interpretation.</td>
</tr>
<tr>
<td>Relationship-centred care</td>
<td>An approach to patient-centred care which emphasises the importance of interaction between people as the foundation for therapeutic care.</td>
</tr>
<tr>
<td>Respondent validation</td>
<td>Cross checking of research findings with respondents.</td>
</tr>
<tr>
<td>Rigour</td>
<td>The process by which trustworthiness is achieved.</td>
</tr>
<tr>
<td>Selective coding</td>
<td>The process of integrating the categories around a core category.</td>
</tr>
<tr>
<td>Social constructionism</td>
<td>A form of constructionism which has the social dimension of meaning at its centre. Meaning arises out of social relationships.</td>
</tr>
<tr>
<td>Substantive theory</td>
<td>A theory that aims to address a phenomenon in a specific situation.</td>
</tr>
<tr>
<td>Symbolic interactionism</td>
<td>A theoretical perspective which recognises that individuals create meaning through interaction with others and with themselves.</td>
</tr>
<tr>
<td>Theoretical integration</td>
<td>The pulling together of the abstract theoretical scheme into a grounded theory.</td>
</tr>
<tr>
<td>Theoretical sampling</td>
<td>A type of sampling which involves identifying and pursuing clues that arise during the analysis.</td>
</tr>
<tr>
<td>Transferability</td>
<td>The ability to transfer the findings to other settings.</td>
</tr>
<tr>
<td>Triangulation</td>
<td>The use of more than one method of data collection to answer a research question.</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>The level of confidence the reader can have in a study.</td>
</tr>
<tr>
<td>Yellow flags</td>
<td>Factors which have been found to be predictive of chronic disability.</td>
</tr>
</tbody>
</table>
Appendix 1

Response to Ethics Committee
1st October 2007

Dear Mrs Austin,

Application for Ethics committee Approval (Ref: 07/Q0204/81)

My application for Ethical Approval for my study entitled “Patient-centred care” an exploration of its meaning for musculoskeletal physiotherapists and patients with low back pain, was considered by the Committee on 27th June 2007. Approval was granted subject to some alterations to the documentation and clarification.

I enclose:

1. A revised participant information sheet written as per the NRES guidelines. I have included information concerning the type of questions that will be asked in the interviews. I have also included information about the Independent Complaints Advocacy Service (ICAS). Potential participants are thanked for reading the information sheet, and not for participating as on the original version.

2. A revised Consent Form which has been amended in accordance with the Ethics Committee advice that the patient’s GP does not need to be informed that their patient is participating in the study.

I have enclosed version 1 of both documents for comparison.

I was also asked to establish the University of Brighton’s policy for the archiving of study data and to inform the committee of the university’s requirements. The University of Brighton’s Code of Practice for Research states that primary data is stored for “a period of at least ten years after completion of a research project” (University of Brighton Code of practice for MPhil, PhD and Professional Doctorates, 2007-8). Data collected in my study will therefore be stored in accordance with this policy.
I understand that the revisions are subject to Chairs action. Please contact me should you require any additional information.

Yours sincerely,

Mary Sexton
Tel: 01442 833166 (H)
     07774 444070 (M)
Email: M.T.Sexton@bton.ac.uk
Appendix 2

Ethical approval
08 October 2007

Ms Mary T Sexton
Principal Lecturer
University of Hertfordshire
College Lane
Hatfield
Hertfordshire AL10 9AB

Dear Ms Sexton

Full title of study: Patient-centred care; an exploration of its meaning for musculoskeletal physiotherapists and patients with low back pain.

REC reference number: 07/Q/0209/81

Thank you for your email of 01 October 2007, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The Chair has considered the further information on behalf of the Committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

This Research Ethics Committee is an advisory committee to East of England Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td></td>
<td>29 May 2007</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>1</td>
<td>29 May 2007</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>29 May 2007</td>
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<tr>
<td>Covering Letter</td>
<td>2</td>
<td>01 October 2007</td>
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<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>24 May 2007</td>
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<tr>
<td>Peer Review</td>
<td>Professor Ann Moore</td>
<td>11 May 2007</td>
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<td>Compensation Arrangements</td>
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<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>29 May 2007</td>
</tr>
<tr>
<td>GP/Consultant Information Sheets</td>
<td>1</td>
<td>29 May 2007</td>
</tr>
<tr>
<td>Participant Information Sheet: Patients</td>
<td>2</td>
<td>01 October 2007</td>
</tr>
<tr>
<td>Participant Information Sheet: Physiotherapists</td>
<td>2</td>
<td>01 October 2007</td>
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<tr>
<td>Participant Consent Form: Patients</td>
<td>2</td>
<td>01 October 2007</td>
</tr>
<tr>
<td>Participant Consent Form: Physiotherapists</td>
<td>1</td>
<td>29 May 2007</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td>1</td>
<td>01 October 2007</td>
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<tr>
<td>Poster - &quot;Volunteers Wanted&quot;</td>
<td>1</td>
<td>29 May 2007</td>
</tr>
<tr>
<td>Interview Schedule For Patients</td>
<td>1</td>
<td>29 May 2007</td>
</tr>
<tr>
<td>Sponsor's CV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation. If they have not yet done so, R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.


Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at: https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx
We value your views and comments and will use them to inform the operational process and further improve our service.

07/Q0204/81 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project

Yours sincerely

Professor Elaine Sherstone
Dr Steve Eckersall
Chair

Email: jenny.austin@nhs.net

Enclosures: Standard approval conditions SL-AC2

Copy to:

Mrs Jayne Ingles
Clinical Research Centre
University of Brighton
49 Daley Road
Eastbourne
East Sussex
BN20 7UR

Sue Hall, Administrator for RM&G
HertNet
University of Hertfordshire Q217
College Lane
Hatfield Herts
AL10 9AB
Appendix 3

Response from Research and Development Panel
Dear Mary

Re: RD2007-98 - Patient Centred Care Project

Further to your proposal being discussed at the R&D Steering Group recently, we write to inform you that we are arranging for an external independent review of your project.

We will contact you again when we have heard the result.

Yours sincerely

Adam Young
Appendix 4

Response from External Reviewers
“Patient-centred care”; an exploration of its meaning for musculoskeletal physiotherapists and patients with low back pain

Comments on design and methodology
Susan Cottam & Dr David Wellsted, January 2008

The study aims to explore qualitatively the perceptions of patient musculoskeletal physiotherapy practice. The concept of patient defined and it has been recommended that the physiotherapy profession needs to explore its meaning within a physiotherapy context exploring patient-centred care and are phenomena, particularly from a patient perspective.

Study design and methodology
The protocol is generally well written and I believe it is addressing an important question for clinical practice. The methodology proposed is question but I would suggest the following issues are considered:

1. Although it is commented that current theory on patient centred care is not clear or unified, nevertheless a summary of current thinking would be useful a tool for comparison with the study’s findings. Without some form of benchmark, the study findings will only represent what is currently happening in practise in a single centre, which may be far from a successful person-centred model and therefore not suitable for wider dissemination.

2. Alternatively, the researcher could state which models or measures have been introduced within the particular centre under study to effect patient-centred care (if indeed this is the case) and then use the findings of the study to show how these measures have influenced the nature of care offered.

3. Evidence of findings from the pilot study and a draft of the semi-structured questionnaire would also be helpful to determine how the theoretical starting point for the study relates to existing theoretical models.

4. The sample size (40x3 interviews) is very large – how practical is this from a time and organisation perspective? Just one fifty minute transcript could take many hours to transcribe and analyse, therefore analysing up to 120 would be a very big task. Sample sizes in grounded theory can be as low as six or eight, provided the participants are appropriate to the objectives of the study.

5. What will the ratio of patients to therapists be in the sample? Will discrepancies between patient and therapist accounts be explored?

6. How will patients be recruited for theoretical sampling (other than by re-questioning existing participants?). Would this take the form of referrals, and if so from whom?
7. Finally, I feel the relationship between the University of Brighton and the University of Hertfordshire needs clarification.

Summary
I believe the critical issue for this protocol is that there is no framework within which to place the new model of patient-care that is proposed. I suggest that either a consideration of the existing theory on patient-centred care (such that it is) or a consideration of the measures taken to introduce patient-centred care to the centre under study (if such measures have been implemented) are required to produce a theory which is embedded within a suitable framework and therefore appropriate for wider dissemination.
Appendix 5

Response to the External Review
"Patient-centred care"; an exploration of its meaning for musculoskeletal physiotherapists and patients with low back pain.

RD2007-98 Patient-centred Care Project

Response to comments by Susan Cottam and Dr David Wellstead.

Thank you for the comments regarding the study design and methodology of the study. I am pleased that the reviewers believe that the study is addressing an important question and that the methodology is appropriate to the question. I have addressed the points they have raised below.

Points 1 and 2
I appreciate the comments regarding a benchmark and below is a summary of current thinking. I felt it was more appropriate to respond to point 1 rather than point 2 as the model of care within West Herts is not the focus of my study.

A summary of current thinking in relation to Patient-centred care.

The term "patient-centred medicine" was introduced by Balint and colleagues who contrasted it with "illness-centred medicine" (Balint et al., 1969). Since that time numerous definitions and descriptions have been proposed, generally including aspects such as patient's preferences, sharing of information, involvement in decision-making and the need for an understanding of the patient's perspective. Patient-centred care has perhaps been explored most fully in medicine, particularly within general practice. Mead and Bower (2000) suggest that patient-centredness is generally associated with what it is not – the biomedical model. The traditional medical model focuses on disease rather than the person with the disease (Bauman et al., 2003). It has been challenged for over-simplifying illness by not taking into account the social, psychological and behavioural dimensions of illness. Hence its value for the management of chronic illness has been questioned. Based on a review of quantitative studies that have attempted to measure patient-centredness, Mead and Bower (2000) propose that five distinct dimensions describe patient-centred care; a biopsychosocial perspective; understanding the individual's experience of illness – the patient-as-person; sharing power and responsibility; the therapeutic alliance and the influence of the personal qualities of the doctor – the doctor-as-person. The authors however express uncertainty as how to best operationalise and balance these dimensions.

There appears to be agreement in the literature that patient-centred care is not a single dimension but a multi-faceted construct. One of the most influential models is by Stewart et al., (2003) who view it as a holistic concept in which six interconnecting components interact with each other in a format unique to each therapeutic encounter (Figure 1). Stewart et al., (2003) claim that their approach differs from others in that it is both a model and a clinical method. It provides a theoretical framework and strategies for implementation in practice. The model
was developed in Canada but its applicability to the UK was broadly supported by a study by Little et al., (2001). The researchers explored patient preferences for patient centred consultation in general practice. They found that patients strongly want a patient-centred approach. Three important domains from the patient’s perspective were communication, partnership and health promotion. Stewart (2001) suggests that this and other studies support an emerging international definition of patient-centred care.

Whilst the study by Little et al (2001) found that primary care patients strongly favoured a patient-centred approach from their general practitioner, others report conflicting results. Say et al., (2006) in their review of patients' preferences for involvement in medical decision-making, found that patient's preferences for involvement were very variable and influenced by a number of factors including demographic factors, experience of illness and medical care, health status, type of decision (minor compared to more serious illness, behavioural decisions, major medical decisions), attitudes towards illness and their relationship with their clinician. In addition there may be a temporal dimension with patients' preferences altering at different stages of their illness.

Swenson et al., (2005) also found that patients have different communication preferences in the physician-patient relationship and recommended that physicians should identify patient communication preferences. This is supported
by Stewart (2001) who argues that being patient-centred involves taking into account patient’s desire for information and responding appropriately. It may be that this sensitivity to appropriate patient involvement that is key to patient-centred care.

Another important theoretical framework is that of evidence-based practice. The challenge of integrating “evidence-based medicine” and “patient-centred medicine” has been recognised in the literature. Bensing (2001) indicates that they have little in common; in contrast Stewart et al., (2003) suggest that they are “synergistic” arguing that there is an increasing volume of literature to support the patient-centred clinical method.

Whilst patient-centred care has been the subject of considerable interest in general practice, within physiotherapy, and in particular in musculoskeletal physiotherapy, it has not attracted the same level of discussion. The practice of musculoskeletal physiotherapists has certainly been the subject of interest in the past 20 years particularly in relation to clinical reasoning. The model by Jones (1995) (Figure 2) reflects the collaboration between the therapist and the patient in the decision making process, while the model by Higgs and Jones (2000) (Figure 3) indicates that the clients input is key in the clinical reasoning process. However these models are only theoretical, often adapted from others and the extent to which they reflect current physiotherapy practice in the UK is not known.

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**Fig. 2**—Cooperative decision making between patient and therapist (Edwards 1995).
The results of a series studies by a group of therapists from the USA exploring expert practice within physiotherapy does provide some insight into patient-centred care within the profession (Jensen et al., 1990; Jensen et al., 1992; Jensen et al., 2000). The studies culminated in a model of expert practice (Resnik and Jensen, 2003) (Figure 4) in which therapists classified as experts were distinguished by a patient-centred approach to care. This approach results from an interplay of other dimensions and guides the clinician’s style of practice. It therefore appears that experts are characterised by a patient-centred approach, however this has not been studied in the UK and to date studies have not considered that patient’s perspective.
It appears therefore that whilst the concept of patient-centred care emerged over 30 years ago, it is still not clear what it is, upon what theories it is based or how to measure it (Epstein et al., 2005). Sumsion (1997) suggests that it has become something of a cliché, whilst Dieppe and Horne (2002) warn that failure to adequately define it may result in misinterpretation and inappropriate use. Within musculoskeletal physiotherapy studies exploring clinical reasoning and expert practice have recognised the collaborative nature of practice and have placed patient-centred care at the centre of practice. The extent to which these theoretical models reflect current practice within the UK, and the extent to which they reflect the patient’s perspective is the topic under investigation in my study. Models from previous studies within general practice provide a tentative framework within which the new model can be placed.

My research question is therefore “What are the perceptions of patient-centred care in contemporary musculoskeletal practice?”

The objectives are:

- to explore patients’ views of patient-centred care at various points during their physiotherapeutic management for a low back pain problem;
- to explore musculoskeletal physiotherapists’ perceptions of patient-centred care;
- to utilise the analytical techniques of Grounded theory to interpret the data;
- to develop a theory/model of patient-centred care in the physiotherapeutic management of low back pain

3. Evidence of findings from the pilot study and a draft of the semi structured questionnaire

For the purposes of the pilot study, purposeful sampling was utilised. Two musculoskeletal physiotherapists currently registered on the Postgraduate Physiotherapy Programme at the University of Hertfordshire and one member of the University staff who had recently completed a course of physiotherapy for an episode of low back pain were interviewed.

The pilot study was primarily a study of my chosen method of semi structured interviews. As such, any findings can only be considered tentative. Three broad areas emerged from the data: the meaning of the concept of patient-centred care; issues with the use of patient-centred care in practice and patient-related issues.

- Meaning of the concept of patient-centred care

The two therapists generated a considerable number of clusters relating to the meaning of patient-centred care. Whilst there was general agreement between them, they provided differing perspectives. For therapist 1 the interaction between therapist and patient was key, for therapist 2 the focus was on the application and integration of a biopsychosocial approach. The patient perspective broadly
reflected the professionals view, but perhaps went even further in terms of involvement. This is illustrated by the fact that the patient’s first response to the question regarding the meaning of the concept was “patient choice”, a term not adopted by the therapists. The patient also wanted the therapists to “put themselves in the patient’s shoes”.

• **Issues with the use of patient-centred care in practice**

The amount of data generated by the meaning of the concept of patient-centred care was exceeded by that relating to the problems and difficulties of implementing the approach in practice. Therapist 2 in particular indicated a considerable personal struggle with adopting a biopsychosocial approach, viewing it as “elitist practice”. Both therapists were critical of therapists who had trained some time ago, perceiving that they are more biomedically orientated and unwilling to change their practice. In contrast younger therapists have been exposed to a patient-centred care approach, but do not necessarily possess the life experiences to deal with the concept. Therapist 1 also suggested that therapists are unwilling to “open up that can of worms” as they do not know what to do with the information. Interestingly whilst patient involvement was identified as a component of patient-centred care, in practice it appears that it may be more therapist-led, “I am actually trying to involve them, but at the end of the day, I am actually saying this is what we are going to do”. The clusters could perhaps be sub-divided into those relating to practice and more personal issues relating to the therapist.

• **Patient-related issues**

The final area of clusters of codes was broadly related to the patient’s role in a patient-centred approach to their management. These issues were identified by both physiotherapists as applicable to some of their patients. They included patients adopting a biomedical approach; lacking in understanding and appreciation of a biopsychosocial approach, not wanting to change their biomedical perspective, being unaware of research findings, lacking in understanding of physiotherapy, lacking in motivation, lacking interest, adopting a passive role and being reluctant to volunteer information.

In summary, as a result of my preliminary analysis of the interview data a large number of clusters emerged from the data. Whilst these require reduction and refinement they provided a useful starting point for the next stage of the research. The findings are highlighted some interesting issues, particularly with regard to the issues surrounding the practical application of a patient-centred approach and these helped to formulate the interview schedules for the physiotherapists and patients.
Interview schedule for physiotherapists

- Introduction to the study
- Demographic questions:
  - Number of years qualified
  - Postgraduate education
- What does being a physiotherapist mean to you?
- Describe your particular practice philosophy, (your beliefs, aims) in your management of patients with low back pain.
- In your opinion what is patient-centred care?
- What does patient-centred care mean for you in your individual sessions with patients?
- What do you think patient-centred care means for patients?
- Do you think a patient-centred approach influences the outcome of care in any way?
- Do you feel that patient-centred care is encouraged or discouraged and in what ways?
- Do you feel you could be more patient-centred? - if the answer is yes – How do you envisage you could be more patient-centred in your everyday practice?
- What might help you as a practitioner to become more patient-centred?

Interview schedule for patients

- Introduction to the study
- Demographic questions:
  - Did you see a physiotherapist for a single consultation or are you receiving a course of treatment?
  - When did you start your physiotherapy treatment?
  - How many sessions have you had to date?
  - Before you started your physiotherapy treatment or before your consultation, what were your expectations of physiotherapy?
  - What do you think patient-centred care means?
  - Have you heard the term before and if so when?
  - Do you feel that the physiotherapy you have received/are receiving is patient centred?
  - What makes you feel like this?
  - Do you feel that physiotherapy could be more patient-focused and if so, in what ways?

Point 4. Sample size.
I am unsure where the reviewers found the figure of 120 interviews. The proposal indicates that a sample size of up to 40 is estimated. It is anticipated that this figure will be the maximum. In grounded theory data collection and analysis occur
simultaneously. Sample sizes are therefore variable but need to be sufficient to enable to development of a theory. I appreciate the reviewers comments regarding the length of time taken to transcribe and analyse a single transcript as this was indeed my experience in the pilot study.

**Point 5. Ratio of patients to therapists and exploration of discrepancies.**
The ratio of therapists to patients will be approximately equal – but this will depend on the categories that emerge from the data analysis. Discrepancies between therapists and patients will be explored in subsequent interviews but there will be no attempt to “match” the accounts from therapists and patients.

**Point 6. Recruitment for theoretical sampling.**
Theoretical sampling can refer to either the way that the sample is chosen to proactively fill gaps in the emergent categories, or to clarify or confirm the content of the emergent categories. This leads to more robust category formulation. In terms of recruitment this may be through sampling of people or it could be through selective sampling of data as a result of what I begin to selectively hear in the interviews.

As my sample will be volunteers I may select what I will transcribe from the interview because I am actively searching for responses to particular questions, people who have had certain experiences and so I will adjust my questioning in the interview to focus more on a particular issue and or selectively choose what to transcribe.

**Point 7. Clarification of the relationship between the University of Brighton and the University of Hertfordshire.**
I am currently registered on the Professional Doctorate in Health and Social Care course at the University of Brighton. The study is being carried out as part of the academic course of study. The University of Brighton’s Faculty Research Ethics and Governance Committee have approved the study and the University of Brighton is acting as sponsor for the study. My supervisors are Professor Ann Moore and Dr Charlotte Ramage.

My study has the support of my employer - the School of Health and Emergency Professions at the University of Hertfordshire. Both Professor Ann Moore, my supervisor from the University of Brighton and Dr Karen Beeton, Associate Head of School of Health and Emergency Professions at the University of Hertfordshire, have confirmed that there is no conflict of interest between the two institutions.

Mary Sexton
31st January 2008
References


Appendix 6
Research and Development Approval
Research & Development Department

Verulam Wing
Hemel Hempstead General Hospital
Hillfield Road
Hemel Hempstead
Herts
HP2 4AD
Tel: 01442 287473
Tel: 01923 844495
Fax: 01442 287278

7 February 2008

Ms Mary Sexton
Principal Lecturer
University of Hertfordshire
College Lane
Hatfield
Herts. AL10 9AB

Dear Mary,

Re: RD2007 -98 Patient-Centred Care Project

Following review by the Research and Development Committee, I am pleased to confirm that the above project now has Trust approval to recruit patients at Watford General, Hemel Hempstead General and St Alban’s City Hospitals.

May we remind you that the Principal Investigator is responsible for ensuring that research is conducted in accordance with the Department for Health Research Governance Framework. It must also comply with the law, all internal Trust policies and processes and any relevant good practice guidance. The research may be subject to internal or external monitoring.

Should you have any queries or require further information, please contact the Research & Development office on the above numbers.

The WHHT Research & Development Steering Group has requested that you submit a formal progress report after 18 months.

Best wishes for a successful project.

Yours sincerely,

Dr Adam Young

Director of R&D
Appendix 7

Information sheet
PARTICIPANT INFORMATION SHEET - PHYSIOTHERAPISTS

“Patient-centred care”; an exploration of its meaning for musculoskeletal physiotherapists and patients with low back pain.

REC reference number: 07/Q0204/81

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The study aims to explore the concept of “Patient-centred care”. This concept has become linked with quality health care and is central to the Government plans for the future of the National Health Service. Despite its popularity there is little agreement as to its meaning. Within physiotherapy there has been minimal discussion and physiotherapists have been urged to explore this issue and to seek the perceptions of their patients.

PART 1

What is the purpose of the study?

The purpose of this qualitative study is to explore what is meant by the term “patient-centred care” for patients with low back pain and for physiotherapists involved in their care. The study is being undertaken as part of an educational programme, a Professional Doctorate in Health and Social Care, at the University of Brighton.
Why have I been invited?
You have been invited to participate in the study as you are a Chartered Physiotherapist working for the Musculoskeletal Service for West Hertfordshire. The study will focus on musculoskeletal physiotherapists as musculoskeletal conditions are the most common cause of pain in the United Kingdom. It is anticipated that approximately 40 participants will be recruited to the study.

Do I have to take part?
It is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?
The study will involve an interview of approximately 50 minutes at a time to suit your convenience. The interview will take place in a private room in the Physiotherapy department. The interview will be recorded onto audiotape and then transcribed. Once transcribed, you will be invited to look at the interview notes and to make any additions or changes you feel are necessary. This is entirely your decision. The time taken for this will vary but it is envisaged that this would take approximately an hour. I may wish to contact you again at a later date to discuss themes that emerge from the data analysis. Again your participation is entirely voluntary. The total duration of participation will vary but will range between one and three hours over the duration of the study. The study is expected to finish in April 2009.

Expenses and payments
Payment will not be made for participation in the study.

What will I have to do?
You will have to participate in an interview during which you will be asked for your opinion of patient-centred care in musculoskeletal physiotherapy, what is means for patients, how it may influence outcomes and the extent to which it is encouraged or discouraged in practice. There are no other requirements for participation in the study.

What are the possible disadvantages and risks of taking part?
There are no risks associated with the study. The only possible disadvantage is the potential for the interview questions to cause emotional upset or embarrassment. Although it is not envisaged that you will be disturbed by the
interview questions, should this occur the interview will be stopped. You will be advised to discuss your concerns with the Superintendent Physiotherapist.

**What are the possible benefits of taking part?**
There is no apparent benefit to individual participants. However, implementing a patient-centred care approach requires a clear understanding of its meaning in relation to the therapeutic encounter. Physiotherapists have been urged to explore the concept as it is not clear what it is, what it is based upon or how to measure it. Your involvement in this study will assist me in constructing a theory/module of patient-centred care within musculoskeletal physiotherapy.

**What happens when the research study stops?**
No further involvement will be expected when the study finishes in April 2009.

**What if there is a problem?**
Any complaint about the way you have been dealt with during the study will be addressed. The detailed information on this is given in Part 2.

**Will my taking part in the study be kept confidential?**
Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes Part I. If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.
PART 2
What will happen if I don't want to carry on with the study?
If you decide to withdraw from the study after the interview, the information collected in the interview will be used for analysis but you will not be approached for any additional information.

What if there is a problem?
Complaints
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (01707 284689). If you remain unhappy you will be advised to contact the Patient Advice and Liaison service (PALS), who will handle the issue in an informal way. The Independent Complaints Advocacy Service (ICAS) will assist you should you wish to complain formally.

Harm
It is not anticipated that the study will result in harm to you however all research studies have to have insurance/indemnity schemes in place. In this study insurance/indemnity for harm resulting from the design or management of the research will be provided by the University of Brighton. The provision of indemnity for negligent harm will be provided by the NHS.

Will my taking part in this study be kept confidential?
All information which is collected during the course of the research will be kept strictly confidential. The interview will be recorded onto audiotapes. The tapes will be transcribed and allocated a code for the purposes of identification. You will not be identifiable from the tapes. The audiotapes will be destroyed once they are transcribed. The transcribed information will be stored in a locked cabinet in my office to which I will have sole access. Electronic data will be stored on my computer and will be password protected.

What will happen to the results of the research study?
The results of the study will form part of the final thesis for the Professional Doctorate in Health and Social Care at the University of Brighton. It is intended that the results will be published in relevant journals and presented at conferences. The findings will be presented to the physiotherapists of the Musculoskeletal service for [location]. A summary of the findings will also be made available to you. The use of direct quotes to illustrate key points is common in this type of research. The quotes will be anonymised so that it will not be possible to identify you from the quote.
Who is organising and funding the research?
The University of Brighton is acting as sponsor for the study. There is no external funding involved.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Hertfordshire Research Ethics Committee. You will be given a copy of the information sheet and a signed consent form to keep.

Further information and contact details
If you wish to seek further information about the study or independent advice as to whether you should participate, please contact: Dr Karen Beeton, Associate Head of School, School of Health and Emergency Professions, University of Hertfordshire, College Lane, Hatfield, Herts AL10 9AB. Tel: 0170728

Thank you for taking the time to read this information sheet.

Mary Sexton (M.T.Sexton@bton.ac.uk)
Appendix 8

Interview Guide
“Patient-centred care”; an exploration of its meaning for musculoskeletal physiotherapists

INTERVIEW GUIDE

- Introduction to the study
- Demographic questions:
  - Number of years qualified
  - Postgraduate education
- How would you describe your particular practice philosophy, (your beliefs, aims) in your management of patients with low back pain.
- In your opinion what is patient-centred care?
- What does patient-centred care mean for you in your individual sessions with patients?
- What do you think patient-centred care means for patients?
- In your experience how does a patient-centred approach influence the outcome of care?
- In your experience tell me about how you consider patient-centred care is encouraged or discouraged?
- How do you envisage you could be more patient-centred in your everyday practice?
- What would help you to be more patient-centred?
- Is there anything else that you would like to add that has not already been covered in this interview?
- Thanks for participation
Appendix 9

Revised Interview Guide
Interview guide

Second round of interviews

- **Introduction**
  - Second round of interviews – questions are building on previous ones and also making sure I have not missed anything

- **Years qualified**

- **Philosophy of care for LBP**
  - Ultimate goal
  - What do you consider are currently the key professional drivers in MS physiotherapy – where is the pendulum?

- **Perception of the term PCC**

- **Patient factors**
  - The patient themselves has been identified as an influencing factor in PCC
  - Is this something you can identify with?
  - Patient expectations have been mentioned as key – what are your thoughts about this?
  - What factors influence their expectations?
  - To what extent do you question the patient about their expectations?

- **The therapist** has also been identified as an influential factor in PCC
  - What is it about the therapist?

- **Therapeutic alliance**
  - Tell me your views on the relationship that develops between the therapist and patient
  - How do you view this in terms of PCC
  - Is care compromised if you are unable to develop the relationship
  - What factors may prevent you from developing a relationship?
  - How do you try and address this?
  - How important to you is continuity of care

- **Gaining/giving information**
  - The provision of information to patients is part of the role of physiotherapists – how do you ensure that your explanations make sense to the patient
  - How do you determine patients views of their problem in addition to all the other information you collect
  - When it comes to assessing all the potential factors that may be contributing to a patients problem – how comfortable/confident do you feel in adopting that line of questioning
  - On completion of the assessment you invariably have a great deal of information – what is your next step
• When it comes to **formulating a management plan** – How do you go about getting agreement
  - To what extent do you consider patients want to be involved?
  - Tell me how you build in choice
  - Is there anything you do to determine the patient’s ability or confidence in being able to undertake their role in the management plan
  - If there is any conflict/divergence here – how do you manage
  - Hands on versus self management is a potential area of conflict

• What strategies have you found helpful in managing non-compliance
• What are the factors that make it difficult for you to be patient centred
• What would help you
Appendix 10

Consent form
CONSENT FORM

“Patient-centred care”; an exploration of its meaning for musculoskeletal physiotherapists and patients with low back pain. 07/Q02024/81

Researcher: Mary Sexton

Participant Identification Number for this trial:

<table>
<thead>
<tr>
<th>I have read and understood the information relating to this study. I have had adequate opportunity to discuss any issues I may have relating to the study and any questions have been answered to my satisfaction.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand that my participation in the study is voluntary and I may withdraw from the study at any time.</td>
</tr>
<tr>
<td>I understand that that my interview will be recorded on audiotape and that tapes will be transcribed and allocated a code for the purposes of identification.</td>
</tr>
<tr>
<td>I understand that I will be able to review the interview data once it has been transcribed from the tapes. I may also be contacted in the future for further information.</td>
</tr>
<tr>
<td>I understand that all the information I provide will be kept confidential and that I will not be identifiable in any future publications relating to this study.</td>
</tr>
</tbody>
</table>

**Participant:**
Signed: 
Name:  
Date:  

**Researcher:**
Signed:  
Name:  
Date:  

When completed, 1 for participant; 1 for researcher site file.
Appendix 11

Reflections after the interviews
<table>
<thead>
<tr>
<th>Participant</th>
<th>Reflections</th>
<th>Relation to previous interview</th>
<th>Considerations for next interview</th>
</tr>
</thead>
</table>
| 1          | • Surprised that the participant was a clinical specialist with less than 6 years of experience and no formal PG qualifications  
• Did this influence my questioning?  
• Found some of the questions thought-provoking  
• My preconception of the clinical specialist role was an issue - surprised that the participant felt that triage patients have the same experience as other patients  
• Surprised at participant's level of maturity  
• An informative interview – did I get the necessary depth?  
• Need to make more use of probes  
• Incorporated some leading questions  
• Good at restating what participant had said - worked well in clarifying points | • Self-management overall philosophy  
• Assessment is vital  
• Using tests to convince patients  
• Concepts of patient expectations and their understanding of their LBP are important  
• Getting the patient on-board – physiotherapist is leading the process  
• Individuality of the patient  
• Addressing psychosocial issues – challenging - opening a can of worms  
• Value of experience  
• Patient mileage is key |
| 2          | • Experienced clinician with considerable PG education  
• Strong professional identity  
• Very supportive of the Department especially the mentoring/supervision  
• Reflective in terms of own performance  
• Critical of the level of research and clinical guidelines  
• I did not feel in control of this | • Self-management supported  
• Assessment supported  
• Confirmed use of tests as an educational tool  
• Expectations again identified as influential  
• Value of experience confirmed – especially when dealing with complex issues  
• On board confirmed | • Lack of guidelines for managing back pain  
• Sense of the physiotherapist being in control - discussion and explanation to get them on board  
• Striking a deal – involvement is important  
• Do patients want choice?  
• Many constraints – red-tape, resources  
• How is patient involved? |
<table>
<thead>
<tr>
<th>Interview</th>
<th>Self-management supported</th>
<th>What happens if they do not wish to be?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost focus at one stage and found it difficult to get back on track</td>
<td>Self-management supported</td>
<td>What happens if they do not wish to be?</td>
</tr>
<tr>
<td>Felt the participant had an agenda – wanted to say certain things</td>
<td>Assessment supported</td>
<td>What happens if they do not wish to be?</td>
</tr>
<tr>
<td>Probing helped</td>
<td>Critical of the constraints on physiotherapists</td>
<td>What happens if they do not wish to be?</td>
</tr>
</tbody>
</table>

| Participant very focused on the needs of the patient | Discussion and explanation supported – physiotherapist leading | Therapeutic relationship as central |
| Strong sense of professionalism | Experience supported | Communication skills of the physiotherapist |
| Identified the therapeutic relationship as vital | Addressing psychosocial issues recognised as challenging | Pursue concept of choice |
| Personal qualities of the physiotherapist identified as important | | |
| A more productive interview | | |
| Still using leading questions | | |
| Interview guide much less of a prop | | |
| Feeling more comfortable to pursue the direction taken by the participant | | |

| Very experienced clinician | Strong support for the therapeutic relationship and involving the family | Self-responsibility |
| Very experienced and experienced in a number of different areas including women’s health | Communication skills of the physiotherapist are paramount | Managing non-involvement |
| Strong emphasis on a hands-off approach to management - found this a bit disconcerting – what about patient’s choice? | Constraints identified – but has strategies to work around these | Use of classes |
| Physiotherapist has a professional remit | No issues with addressing complex issues – experience is key | Balancing professional agenda with patient involvement |
| Comfortable and relaxed interview | | Pursue therapeutic relationship |
| Good use of probing | | |
| Very much led by the participant but main themes covered | | |
| 5 | Interview took place in the staff office – one interruption  
Relatively inexperienced therapist in terms of out-patients  
Identified challenges with involving patients and goal-setting  
Identified reconceptualisation of the problem as a strategy  
Interview required careful handling as the participant was clearly nervous  
Talked quickly and lost focus a couple of times  
Inexperience in out-patients was evident in responses – lacked confidence  
I tended to let the participant lead – so maybe did not achieve the depth I could have | Concepts of patient expectations and their understanding of their LBP considered as key  
Managing back pain and complex factors a challenge  
Communication identified as key to managing non-involvement and encouraging self-responsibility  
Mixed views on classes  
Therapeutic relationship supported but balanced with professionalism | Involving patients in decisions  
Goal setting  
Strategies for managing non-involvement  
Use of classes  
Continue to pursue choice |
|---|---|---|
| 6 | Informative interview  
Particularly identified education as integral to role  
Identified issues with culture and language barriers  
Discomfort with manipulating patients to fit with what physiotherapy can offer  
A much more conversational interview and hence a lot of rich data | Expectations and management of them again considered important  
Communication skills of the physiotherapist are paramount  
Value of experience  
Value of therapeutic relationship  
Mixed views on classes  
Challenges of goal setting  
Limited choice - cause of some anxiety | Goal-setting and decision making  
Culture and language barriers  
Choice – issues surrounding this |
| 7 | Most in-experienced of the participants  
Although now based in out-patients | Challenges of managing expectations  
Lack of experience an issue when managing LBP | Goal-setting and decision making |
had spent a lot of time ward-based
- Identified continuity of care as particularly important
- Appeared the least skilled in managing non-involvement
- A useful interview providing the perspective of a more junior member of staff
- However – I did not get more depth in terms of goal-setting
- Goal-setting often therapist-led
- Supported cultural and language differences as an issue
- Support for therapeutic relationship
- Choice strongly related to self-responsibility

8
- Very experienced clinician – all responses were carefully considered
- Initially appeared rather reticent and reserved.
- Identified the issue of unpicking the presenting problem and working with factors amendable to physiotherapy
- Negotiation and persuasion key strategies in decision-making and goal-setting
- I found the initial stages of the interview challenging and tended to revert to more direct questioning. As time went on the participant appeared to relax and the interview became much more conversational. My questioning became more open and the data obtained became richer
- Supported the individuality of the patient
- Goal setting – understanding of the problem is key
- Supported key role of therapeutic relationship
- Supported the influence of the physiotherapist

9
- Initially I perceived that the participant appeared rather detached however it quickly became evident that this was not correct.
- Supported key role of therapeutic relationship
- Supported the individuality of the patient

<table>
<thead>
<tr>
<th>Strategies for goal-setting</th>
<th>8</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
</tr>
<tr>
<td>• A comfortable and informative interview</td>
<td>• Expectations and management of them again considered important</td>
</tr>
<tr>
<td>• Good level of depth achieved in terms of the exploration of goal-setting</td>
<td>• Supported the communication skills of the physiotherapist</td>
</tr>
<tr>
<td></td>
<td>• Critical of the constraints on physiotherapists</td>
</tr>
<tr>
<td></td>
<td>• The influence of the physiotherapist was evident. The participant did not appear to be particularly flexible in accommodating the patient</td>
</tr>
<tr>
<td></td>
<td>• Strategies for managing non-involvement involved explanation and emphasising self-responsibility</td>
</tr>
</tbody>
</table>
Appendix 12

Certificate of Participation
Certificate of participation

XXXXXXXX

participated in a the research study:

“Patient-centred care” an exploration of its meaning for musculoskeletal physiotherapists and patients with low back pain (Ref: 07/Q0204/81)

On (date)

The study was carried out by Mary Sexton MCSP as part of a Professional Doctorate in Physiotherapy at the University of Brighton.
Appendix 13

Example of a Memo
What does patient-centred care mean to therapists?

A number of key components have been identified.

**The initial assessment** is part of the professional role of the therapist. Is it a category or the context? I think it is more the context??

It is a combination of conveying and gathering information. ?? it consists of a working discourse. Patient centred care is about individualising/personalising this professional remit.

- Gathering information involves: Questioning the patient, Listening to their responses, Picking up cues from the patient to tailoring subsequent responses, Focusing on what is important for the patient. This relates to the professional role of the therapist and enables them to obtain the patient’s perception of their problem.

- Conveying information involves the provision of information about the patient’s problem and the role of physiotherapy in their problem. Therapists perceive that this enhances the patients understanding and awareness of their problem and the patient will be more realistic about the likely impact of physiotherapy in long term conditions.

The therapists personalise / make it patient-centred by developing a relationship with the patient.

Developing a relationship with the patient is vital to this process, particularly when managing patients with chronic pain. There is also a perception that it influences outcomes. How do they develop this relationship:

- They do thus by developing a rapport with the patient.
- Therapists adopt a number of strategies to facilitate this process – particularly getting to know the patient as a person, talking to them, listening to them, identifying common interests.
- The interpersonal skills of the therapist are a factor being empathetic and sympathetic, thoughtful, considerate but also professional and working within their professional boundaries
- The process is facilitated by having quality time for the patient

The development of an effective rapport facilitates the therapist to explore the often complex factors that may be contributing to patient symptoms ie the psychosocial factors. Not sure if this is a separate category – it was a very common initial code.

Through the personalised assessment the therapist develops a greater understanding / appreciation of the issues that may affect the management of the patient’s problem and the patient’s understanding of their problem is perceived to increase.
The assessment process culminates in the negotiation of an agreed management plan between the therapist and patient.

- Through discussion/explanation/facilitation - there is a reconciliation of therapist and patient goals.
- Managing expectations was a very common initial code – need to look at this.
- Therapists indicate it is broadly led by them – getting the patient around to the therapist point of view - Need to explore more the element of choice here??
- As a result the patient is on board with the treatment plan, therapist and patient are singing from the same hymn sheet, outcomes are better, compliance is enhanced.

What about the role of the physiotherapist in PCC?
2 elements appear to be key:

i) Interpersonal skills are key to developing and maintaining a relationship with the patient – can this be looked upon as a mediating factor that facilitates this process?

ii) Professional skills – recognising their professional role and boundaries, being reflective – not sure where this fits? Is it something that underpins the whole therapeutic relationship?

I am struggling on the next section
In the context of on-going patient management PCC here relates to

- Monitoring/reviewing the individual patient’s progress – is this the category?
  - Managing lack of progress
  - Reviewing the effect of interventions
  - Trying out different treatments and reviewing their effects (negotiated empiricism)
  - Managing non-compliance – therapist approach ranges from being facilitatory to being directive the longer this goes on

Mediating factors:

- Patient non-compliance
- Difficulty in managing chronic low back pain – as there is no set format

Consequences:

- Some patients may fail to complete a course of treatment
- Some patients will be dissatisfied with their treatment

Not sure where this comes in?

For patients with chronic pain the therapists adopt a self-management approach rather than utilise specific techniques:

- Exercises
• Advice
  o Posture
  o Lifestyle changes
  o Pacing
  o General fitness
• Use of classes – back fitness
• Education

Do therapists ask patients about their readiness and confidence in adopting this approach?
Appendix 14

Poster presentation at the Kinetic Control and Manipulation Association of Chartered Physiotherapy Conference
“Patient-centred care”: an exploration of its meaning for musculoskeletal physiotherapists.

Mary Sexton, Ann Moore, Charlotte Ramage
School of Health and Emergency Professions, University of Hertfordshire, Centre for Clinical Research, University of Brighton
m.t.seston@herts.ac.uk

INTRODUCTION
The centrality of the patient to health care has been increasingly recognised both politically and professionally. Patient-centred care has become synonymous with high-quality care and a number of studies have reinforced patient’s desire for, and the positive impact of the approach. Although the concept emerged over 30 years ago, it is still not clear what it is, upon what theories it is based or how to measure it. Whilst the concept has been explored within medicine, nursing and other allied health professions, within physiotherapy there has only been minimal discussion.

In an exploration of expertise within physical therapy, a patient-centred approach, characterised by collaborative problem-solving and the promotion of patient empowerment, distinguished the practice of experts. Communication was a key dimension identified by patients in a study of patient-centred physiotherapy for chronic low back pain.

The aim of this research is to construct a theory of patient-centred care in musculoskeletal physiotherapy based on a Grounded Theory approach. Phase one involved an exploration of musculoskeletal physiotherapists’ perceptions of patient-centred care. Phase two will explore patients’ views at various points during their physiotherapeutic management for a low back pain problem.

METHOD
Five participants provided informed consent. The participants ranged from band six to clinical specialist and had been in the profession between 6 and 25 years. Interviewee semi-structured interviews were carried out with the therapists. The semi-structured format allowed flexibility in the order and wording of questions. Each interview lasted approximately 60 minutes. All interviews were audio-taped and then transcribed verbatim.

ANALYSIS
Data analysis began with line by line coding facilitated by the use of NVivo. Subsequent analysis utilised axial coding to establish a coding of a small number of higher order and more abstract categories.

RESULTS
Analyses revealed a complex construct in which there is an interplay of several key categories. The “core category” appears to relate to the recognition of the individuality of the patient and their involvement in their physiotherapy management. A process is evident whereby other categories support this involvement towards the ultimate goal of patient self-management.

The working discourse refers to the gathering and conveying of information particularly in the context of the initial encounter with the patient. This enables the therapists to obtain the patient’s perception of their problem and to increase the patient’s understanding of their problem and the role of physiotherapy in its management. The establishment of a relationship with the patient is considered integral to this process.

The patients perceive that the agreement of an individually tailored management plan is facilitated by this process of explanation and education. Although this is reached through discussion, negotiation and compromise, it is a therapeutic process.

There are a number of influences on the process including:
• the attitudes and expectations of the patient
• the personal and professional attributes and qualities of the therapist
• professional issues
• consultation level factors
• operational factors

CONCLUSIONS
In this study physiotherapists view patient-centred care as an individualised process within the confines of their professional remit. The extent to which this reflects the patient’s views will be explored in the next phase of the study.

ACKNOWLEDGEMENTS
I would like to acknowledge the funding provided by the Charitable Trust of the CSP and a Doctoral level study award provided by the MACP.

REFERENCES
Appendix 15

Poster presentation at World Confederation of Physical therapy Conference
Patient-centredness: a conceptual framework for musculoskeletal physiotherapy

Sexton, M. T.1, Moore, A. P.1, Ramage, C. M.2
1University of Hertfordshire, 2University of Brighton

Background

The centrality of the patient to health care has been increasingly recognised both politically and professionally. Patient-centred care (PCC) has become synonymous with high-quality care and a number of studies have reinforced patient's desire for, and the positive impact of the approach. Although the concept emerged over 30 years ago, it is still not clear what it is, upon what theories it is based, or how to measure it. Physiotherapists have been urged to explore PCC in relation to their practice.

Procedure

Individual semi-structured interviews were used as the method of data collection. The interviews were audio taped and transcribed verbatim.

Analysis

Analysis consisted of a process of open, axial and selective coding resulting in a substantive theory with a core category and three sub-categories.

Purpose

The aims of this study were:

- To explore musculoskeletal physiotherapists' perceptions of PCC in relation to the physiotherapeutic management of low back pain.
- To construct a theory of PCC based on Grounded Theory methodology.

Methods

Participants

Initially purposive sampling was used to select participants. Subsequent sampling was theoretical whereby analysis of the data informed the sample selection. Nine musculoskeletal physiotherapists agreed to participate in the study.

Findings and discussion

The findings suggest that PCC is a dynamic process of Engaging the patient in a working alliance (Figure 1), a collaborative relationship in which the patient and physiotherapist reach agreement regarding the goals of management and how to achieve them. Three interactions were identified as integral to the success of the process: interpreting the problem, reconciling perspectives and developing a therapeutic alliance. It was evident that engaging patients with low back pain is not always straightforward but associated with a number of issues. This was particularly apparent in relation to incorporating the patient's perspective into the decision-making process. Drawing on a number of different disciplines and philosophies, Engaging the patient is proposed to be underpinned by three main concepts: complex responsive process of relating; counselling theory; and strategic action. Together with the findings they form a composite theory of PCC in musculoskeletal physiotherapy practice (Figure 2). Whilst a number of factors at a macro level serve to constrain the process, it is facilitated by micro factors such as effective communication skills, professional experience and local support.

Conclusion and recommendations

PCC in the physiotherapeutic management of low back pain is conceptualised as a process of Engaging the patient. It is a multi-faceted concept that raises a number of issues for physiotherapists. The proposed model may serve to heighten awareness of the interactive processes adopted by physiotherapists, inform the development of interventions and form the basis for further research.

Acknowledgements

The funding provided by the Charitable Trust of the CSP and the MAACP for a Doctoral study award is gratefully acknowledged.

References

Appendix 16

Back Beliefs Questionnaire
We are interested in finding out what you people think about low back trouble. Please indicate your general views towards back trouble.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Agree strongly</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>There is no real treatment for back trouble</td>
<td></td>
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<td>2</td>
<td>Back trouble will eventually stop you from working</td>
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<td>3</td>
<td>Back trouble means periods of pain for the rest of one’s life</td>
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<td>4</td>
<td>Back trouble makes everything in life worse</td>
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<td>5</td>
<td>Back trouble may mean you end up in a wheelchair</td>
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<td>6</td>
<td>Back trouble means long periods of time off work</td>
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<td>7</td>
<td>Once you have had back trouble there is always a weakness</td>
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<tr>
<td>8</td>
<td>Back trouble must be rested</td>
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<td>9</td>
<td>Later in life back trouble gets progressively worse</td>
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</tbody>
</table>