

Patient-centredness in physiotherapy from the perspective of the chronic low back pain patient

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Abstract

Objective To define patient-centredness from the patient's perspective in the context of physiotherapy for chronic low back pain (CLBP).

Design Qualitative study using semi-structured interviews to explore perceptions of various aspects of physiotherapy management of CLBP.

Setting Physiotherapy departments in one geographical area of the UK National Health Service.

Participants Twenty-five individuals who had received physiotherapy for CLBP within the previous 6 months.

Results Six key themes emerged as the dimensions that the participants perceived to be important for patient-centred physiotherapy: communication; individual care; decision-making; information; the physiotherapist; and organisation of care. Communication was the most important dimension, underpinning the five other dimensions as well as being a distinct dimension of patient-centred physiotherapy.

Conclusions Physiotherapists should have an understanding of the six dimensions of patient-centred physiotherapy for CLBP. Improving physiotherapists' communication skills may better facilitate patient-centred physiotherapy, and therefore enhance the experience of physiotherapy for this client group.

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Keywords: Chronic low back pain; Patient-centred; Qualitative

Introduction

References to patient-centred care are abundant in recent literature, particularly in relation to chronic conditions, with policy documents for the UK National Health Service (NHS) stating that care should be patient-centred [1]. In addition, several authors have suggested that physiotherapy should be patient-centred [2,3]. Despite this, research has shown that 'the concept of patient-centred care is complex and contested' [4], and it remains unclear precisely what is meant or understood by the term with regard to physiotherapy.

Chronic low back pain (CLBP) is a condition commonly seen by physiotherapists in primary care [5], and it is suggested that CLBP patients will benefit from a patient-centred approach [6]. However, it is impossible to demonstrate the extent to which physiotherapy is patient-centred, and therefore to assess the possible benefits of such an approach, in the absence of a clear definition.

Several other professional groups, such as nursing, occupational therapy and medicine, have proposed models of patient-centredness; three examples are discussed below. In nursing, Gerteis *et al.* [7] developed a model in an acute medical and surgical context. Important differences between this setting and outpatient physiotherapy departments make the extent to which the model can be applied in the latter questionable. In occupational therapy, Law *et al.* [8] developed a model from the literature rather than practice, with a key emphasis on decision-making. In medicine, the model proposed by Mead and Bower [9] was also developed from the literature, mainly in the context of primary care. It is possible that these theoretical models relate fairly well to physiotherapy in primary care. However, there are several differences between the three models described, suggesting that different professional groups and contexts result in different focuses on aspects of patient-centred care [4], and that a specific model for physiotherapy may be required. Patients' views on some of the dimensions of patient-centredness proposed in nursing, occupational therapy and medicine have been explored. These include involvement in goal setting, treatment plan-

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ning and outcome evaluation [10], decision-making [11,12], the patient–therapist relationship [13] and communication [2,3]. However, it is not clear how these will apply to CLBP patients.

If patient-centred care has the patient at its centre, patients' views are paramount to the development of a model of patient-centredness. This is in keeping with the current drive to involve patients in the design and evaluation of health-care services [14]. In physiotherapy, patient-centredness has been discussed from the professional's perspective [15], but patients' views on patient-centredness appear to be lacking.

A definition of patient-centredness will provide a common language, enable assessment of the extent to which physiotherapy is achieving patient-centredness, and inform the development of strategies to optimise patient-centred physiotherapy. Therefore, the aim of this study was to define patient-centredness, in the context of physiotherapy for CLBP, from the patient's perspective.

Methods

Participants were recruited from seven physiotherapy departments in the Grampian region of Scotland. A purposive sampling frame was developed to ensure representation from the wide range of CLBP patients typically seen in this region [16]. Sampling criteria were: location of physiotherapy, defined as urban or semi-rural [17]; gender; whether or not participants completed their course of physiotherapy; age; and management style (group, one-to-one or mixed). Participants who had attended at least two physiotherapy sessions for the treatment of chronic [18] or recurrent [19] non-specific low back pain [20,21] and had been discharged up to 6 months previously were identified from physiotherapy discharge files. This ensured that participants had experienced physiotherapy treatment as well as assessment, and that they had had some time to reflect on its outcome. Potential participants were contacted by letter, inviting them to return a reply slip if they were interested in taking part in the study. The researcher telephoned the respondents to confirm that they met the study requirements. All participants provided written informed consent. Ethical approval for the study was granted by the NHS Grampian Research Ethics Committee.

Semi-structured interviews were conducted with each participant by the first author (KC), either in their home or in NHS premises (excluding physiotherapy departments) that were convenient for the participant. An interview schedule based on extensive review of the literature was used to guide consistency of the interviews. A copy of the interview schedule is available, on request, from the corresponding author. The study explored several aspects of physiotherapy for CLBP, not only patient-centredness. Therefore, the interviews covered the broad areas of LBP history, expectations of and satisfaction with physiotherapy, involvement, needs and current coping mechanisms. Only the areas that relate to patient-centredness are presented in this paper. All interviews

were recorded on a digital voice recorder, downloaded to a personal computer and transcribed using a digital transcriber. There was one instance where it was not possible to record the interview (due to background noise in the interview location). Instead, notes were taken during and immediately after the interview, with transcribing taking place immediately.

The framework method of qualitative data analysis [22] was employed. Framework analysis facilitates both rigour and transparency during the data management stages; aspects of qualitative research that are often criticised [23]. It also leaves a clear audit trail of the analysis process, which is desirable in qualitative research. Framework analysis involves three main stages: data management; descriptive analysis; and explanatory analysis [24]. Data management began with familiarisation with the data and the noting of recurrent themes, constructing an index and labelling the data with the index. There were a combination of themes derived from the literature and emergent from the data itself. NVivo software was used at this stage. Indexing was conducted largely by the first author (KC), in collaboration with the two co-authors. All three authors independently applied the index to two full interview transcripts; a method that is proposed to guard against bias and enhance the trustworthiness of the data [25,26]. This resulted in subtle refinement of the use of the index, which was subsequently applied to the remaining transcripts. The data were then sorted by theme and summarised in a series of matrix-based charts, retaining the context and language of the respondents at this stage. Descriptive analysis involved identifying dimensions within the data, categorising these dimensions, and finally grouping sets of categories together as classes. Explanatory analysis involved identifying links between sections of and subgroups within the data to try to explore why such associations and subgroups existed. Both the framework charts and interview transcripts were referred to frequently at this stage.

Results

In total, 140 letters were sent to prospective participants. As they were sent out in batches, it was possible to monitor sampling criteria and target the next batch appropriately. Twenty-five participants provided informed consent and were subsequently interviewed; their characteristics are displayed in [Table 1](#).

Two broad dimensions relating to patient-centredness emerged during data analysis: the physiotherapy experience; and the process of physiotherapy. There were 11 themes within these two broad dimensions. These are displayed in [Table 2](#) along with the classes of data within each theme. Further inspection and analysis of the data revealed associations between the classes of data within these initial 11 themes. These associations resulted in the emergence of six key higher order themes, with data from each of the initial 11 themes contributing to one or more of the six key themes

Table 1
Characteristics of interview participants

Characteristic	n
Location	
Urban	13
Rural	12
Gender	
Male	5
Female	20
Completed physiotherapy?	
Yes	18
No	7
Age (years)	
18–34	3
3–50	8
51–65	14
Management style	
Group	4
Individual	14
Mixed	7

(Table 2). These six key themes are displayed in Fig. 1 and represent the dimensions that the participants perceived were important for patient-centred physiotherapy.

Communication

Communication was extremely important to and discussed by all the participants, despite the fact that there was no specific interview question relating to it. Communication stood out as a theme in its own right but also contributed to the other five themes to a greater or lesser extent. Most participants were generally satisfied overall with the communication that they had experienced in physiotherapy, but most also suggested ways that communication could have been improved. Participants liked or wanted treatments and diagnoses that were well explained:

‘(…) I know somebody else who went to a back class, and I don’t think they got quite so much in-depth explanation about it, and they just thought this exercises oh God, why do I have to do them? But when you got it really explained to you, and

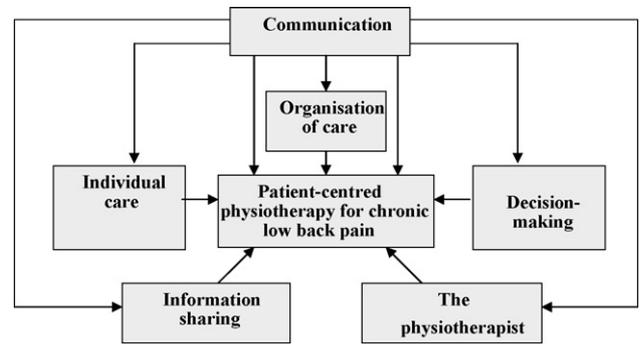


Fig. 1. Six patient-reported dimensions of patient-centredness.

what the benefits, and to keep doing this...’ (Participant 5, 48-year-old female)

‘You know not everybody knows medical speak (...) But, if you have a good understanding in layman’s terms... Ever since then I’ve a clear understanding of what exactly is happening to my back when it goes out, what needs to be done, and how to get back on track.’ (Participant 1, 39-year-old male)

However, specific approaches were more useful for some than others, suggesting that tailoring communication to the individual’s needs is important:

‘If somebody sits and tries to explain, well, they’ll say a technical name and I’ll think I don’t know what that bit is, ken [you know]. But as soon as I saw [physiotherapist’s name], he got a model of the spine and he explained he showed me the bits. It makes it easier for me, it’s clearer, you can actually see what he’s speaking about.’ (Participant 14, 41-year-old male)

‘Well, they showed me diagrams and skeletons and things like that and I was none the wiser [No clearer], ‘cause I was... it was too technical I suppose in a way.’ (Participant 4, 52-year-old female)

Written communication was also discussed, often in a negative manner, suggesting that care should be taken to issue information acceptable to the individual:

Table 2
Themes relating to patient-centredness

Theme	Classes of data	Higher order themes
Advice/explanations	Positive, negative, suggestions, statements	1, 2, 3
Exercises	Satisfaction, attitudes, suggestions, motivation, compliance	1, 2, 4, 6
Interventions	Effectiveness, preferences, opinions	2, 6
Group	Peer support, individual needs, opinions, competence, intensity	2, 3, 4, 6
Involvement	Communication, assessment, decision-making, physiotherapist	1, 2, 3, 4, 5, 6
Individual	Communication, intervention, positive, negative	1, 2, 4, 5, 6
Contact	Individual, group	4, 6
What patients want	Access, quantity, information, treatment	2, 6
Physiotherapist	Competence, personality, communication	1, 4
Duration	Number, length, frequency	6
Organisational issues	Views, waiting time, communication, access	1, 4, 6

Dimensions: 1, communication; 2, individual care; 3, information sharing; 4, the physiotherapist; 5, decision-making; 6, organisation of care.

‘If you have a really bad back, I’m telling you that book, somebody whoever wrote that they’ve never suffered like what I’ve suffered.’ (Participant 2, 57-year-old female)

Good communication was related to participants feeling involved in the physiotherapy process, and participants who were not able to discuss their needs or who received poor explanations did not feel involved. According to the participants, good communication involved: taking time over explanations; using appropriate terminology; listening, understanding and getting to know the patient; and encouraging the patient’s participation in the communication process.

Individual care

Communication played a role in participants perceiving that treatment was individualised to their needs. Listening, understanding and getting to know the patient, and allowing the patient to explain their problem and to question the physiotherapist were recurrently cited in relation to this dimension:

‘You know I think it was the fact somebody was taking an interest I found surprising! It was something I’d never, ever been offered before.’ (Participant 12, 64-year-old male)

When this failed to occur, some participants felt very strongly about it, emphasising the importance of good communication:

‘For me, it seems when I lie on my back, I don’t sleep on my back – I can’t, it’s painful and I said it’s sore, and she was like, no, no, no, I said it is it’s sore, she was like typical man, you just can’t lie and sit at peace for a minute. And I was so annoyed, ken [you know], just, ‘cause I said well I am in bloody pain. . .But she just wouldn’t seem to accept the fact that, no you’re lying down so it can’t be sore. No, you just don’t listen. . .ken [you know].’ (Participant 14, 41-year-old male)

‘First two times they had wrote to my doctor and said I was better and I wasn’t. I was actually worse. They never came to me and said, are you better or anything like that. . .But then they’re writing back saying to the doctor, and it’s totally wrong.’ (Participant 21, 39-year-old female)

Participants liked or wanted both treatment and the delivery of treatment to be individualised. Exercises were commonly discussed. Participants who felt that their exercises made sense to them and were well explained also felt that their individual needs were addressed, in contrast to those who felt that their exercises did not make sense or did not push them hard enough:

Respondent: ‘They gave me like a diagram out the computer and (. . .) she kept saying something about. . .opening up. . .something to do with stomach muscles, I can’t remember what. . .Some kind of balance, you had to get the balance right, I can’t remember. . .Core. . .core. . .’

Interviewer: Core stability?

Respondent: Stability, that’s it. And I haven’t got a clue what she was speaking about! She kept going on about core stability.’ (Participant 4, 52-year-old female)

‘I felt stupid just lying there doing that. I think you should be made to do more. Because I think that’s why it didn’t work for me. . .It wasn’t working me hard enough. I think it could have been more. It does work, but I think you need much more as you go on. Like each time you should get more and more. Although they do say to you, it’s up to yourself. But I think they should actually push you to do it.’ (Participant 21, 39-year-old female)

Participants described the type of exercise as affecting compliance, only doing the exercises that fitted in with their lifestyle, suggesting that physiotherapists need to take this into account when prescribing exercise for CLBP patients:

‘I think the impression a lot of people get is that, that physiotherapists in general give you a recommended type of exercise, which is very specific to the back problem at hand. And these are the types of exercises that you would do on your living room floor. And because of that, people haven’t got the motivation to do this on a daily basis. . .’ (Participant 1, 39-year-old male)

‘I can do them when I’m sitting at my desk or in the car – and I do extra if I feel my back getting sore, it stops it from getting worse. I don’t do them at set times or anything, just whenever. I can be lying in my bed and think, oh, I’ll do some of the exercises, or when I’m sitting at my desk, ‘cause they’re really easy to do.’ (Participant 25, 38-year-old female)

Several of the participants who experienced group rehabilitation felt that their individual needs were not addressed in this setting. Two participants who were prescribed group rehabilitation felt that it was unsuitable for them (one considering it boring and the other embarrassing), and both stopped attending physiotherapy for these reasons. Patients’ needs being met in the group setting appeared to be related to the individual physiotherapists leading the groups:

‘I think there wasn’t the same consistency of what you were doing, and what was happening in the class. There were one or two when I was there, they started at the same time as me, so we were there 6 weeks. We felt some weeks it was a waste of time. . .We were just left. . .I felt, some, sounds very critical, I felt some physios were better than others when it came to the back class. . .They seemed to be more organised, I think that was the key.’ (Participant 21, 39-year-old female)

Common to both group and one-to-one treatment were participants who felt that their treatment was ‘too gentle’ and those who felt they had a ‘good workout’, suggesting that individual adjustments in response to feedback from patients are important. Many participants placed importance on a thorough assessment, feeling that it enabled their treatment to better relate to their needs, and emphasising the importance

that patients seem to place on this aspect of physiotherapy.

Delivery of treatment related to continuity and choice. Participants felt that seeing the same physiotherapist enabled individualised treatment due to the physiotherapist getting to know the patient, and treating them as a ‘person not a number’. Participants who had received one-to-one treatment commonly held this view, whereas those who had received group treatment often felt that there was a lack of personal treatment. Choice was a factor for a minority of participants who felt that their treatment type did not relate to their individual needs, and would have liked a choice of alternative treatment types.

Decision-making

Most participants expressed the view that since the physiotherapist is the professional or expert, they should decide what is best for the patient. However, this was very much linked with communication, since participants were happy for the physiotherapist to make most decisions as long as they were accompanied by good explanations:

Respondent: ‘I tend to not question what the doctor or the nurse or the physio should say. You know if the doctor says you need these pills I’ll take them, so if the physio said you need this Pilates class you know, then I was going to do it.’

Interviewer: You were quite happy for that?

Respondent: . . . Yes I think so. Preferably with a “this is what you need because”, which is what she did. You know, your problem is this, this is what you need to do to improve it.’ (Participant 23, 48-year-old female)

‘I’m coming here for advice and the people that I would expect to see are professionals. So no, I came to listen and be told.’ (Participant 16, 48-year-old male)

However, some participants wanted more involvement in decision-making than they had experienced, suggesting that an individualised, communicative decision-making approach should be adopted:

Respondent: ‘Well they didn’t really ask me. . . well, they just did what they were doing and I went along with it.’

Interviewer: And how did you feel about that then?

Respondent: (pause) I think that’s the reason I got bored. . . Yeah, cause they didn’t ask what I thought, what I thought I wanted. They didn’t ask me what I thought I wanted, they just did what they assumed was physiotherapy.’ (Participant 4, 52-year-old female)

‘Well. . . I think. . . as I said I don’t know what other treatments I could have got. . . if they’d maybe explained that there was different types of treatment, I mean that other lassie [girl] got acupuncture and she got another kind of treatment, I’d never even heard of it. And I think just more information about the kind of treatment you can get really.’ (Participant 13, 51-year-old female)

Therefore, assessing the patient’s wishes regarding involvement in decision-making, and tailoring the subsequent approach to that decision-making appear to be the key factors in patient-centred decision-making with this patient group.

Information sharing

Participants commonly wanted information related to their diagnosis and what it meant for them:

‘I think by the middle or the end of my treatment I would have expected to know what was going on, what was wrong with my back. . . Yeah. I think, if it’s curable or if it’s not. If it’s just going to be a long-term thing. I would like to have found out.’ (Participant 22, 33-year-old female)

‘I think a little bit more education in the way of, what’s actually going on in your back. I mean obviously in layman’s terms, but, to be able to break it down to the general people and say well, look this is how your back’s made up, this is what’s actually happening to your back, and this is the areas you need to be looking at building up on, or working with to try to prevent it.’ (Participant 1, 39-year-old male)

‘I think [I’d have liked] some more insight into the back pain, and really find out what’s going on, you know.’ (Participant 3, 50-year-old female)

Of course, physiotherapists may not always be able to fulfil these needs, particularly where there is no specific diagnosis. However, these results do suggest that the type of information that patients are searching for should at least be explored, and the physiotherapist should explain what information they can confidently provide. Participants also discussed information about group rehabilitation. Some limitations of group rehabilitation have been presented; however, the most recurrent positive comment was that information sharing (particularly with other CLBP patients) was the most helpful part and should be done more frequently:

‘I think it’s helpful. And you learn as well by the other people speaking. Some of them are having the same problems as yourself. So you can relate. And they ask what they’re doing to make themselves better and stuff, what they think helps.’ (Participant 21, 39-year-old female)

The physiotherapist

Two aspects about the physiotherapist were discussed frequently: competence and personality. Most participants felt that their physiotherapists were competent, and felt that physiotherapists in general were the ‘experts on low back pain’ because they ‘know what they’re talking about’ and have a ‘great depth of knowledge’:

‘But, you know, a physiotherapist is a back specialist. They have got an uncanny ability of knowing exactly what it is they are doing in there, and, when they’ve done their job, if you follow their instructions, it gets better, you know, so how

can you not put trust in somebody like that?’ (Participant 1, 39-year-old male)

Although some participants felt that some were better than others, physiotherapists were rarely blamed for poor treatment outcome provided that it was perceived that they had done their best or were thorough.

Participants appreciated consulting a physiotherapist who was caring, friendly, pleasant and professional, and who showed an interest in their patients and made them feel at ease:

‘[The physiotherapist was] caring and interested and really tried to help me. . . The first person that’s ever, ever shown any interest to help me.’ (Participant 8, 61-year-old female)

Abruptness was encountered at times and linked with dissatisfaction:

‘I didn’t like [the physiotherapist]. . . she was quite abrupt, and she basically said, you’re far too stiff.’ (Participant 5, 48-year-old female)

‘[Discussing the physiotherapist’s manner] It was just like it was an ordinary day-to-day job. . . you know. . . it was, it was like being at school to be honest with you, just, sort of get on with it.’ (Participant 3, 50-year-old female)

However, participants who described their physiotherapist as ‘nice’ or competent did not necessarily perceive their treatment as being patient-centred and were not always satisfied with the delivery of their care. Therefore, there appears to be a complex combination of factors, including the persona of the physiotherapist, which combine to produce patient-centred care.

Organisation

Access to physiotherapy and the amount received were important organisational aspects for these participants. Access in the future was a common theme, with participants wanting quick and direct access in the event of a flare-up. Some participants wanted a follow-up or review by the physiotherapist. Waiting times were discussed recurrently, with long waiting times tending to result in dissatisfaction, whilst participants seen in departments offering an early triage appointment were satisfied with their short waiting time. Organisation of appointments was problematic for some participants. This related to rescheduling of appointments by the physiotherapist, confusion surrounding onward referral, or the expectation of a review appointment that did not occur. This suggests that communication and efficiency regarding these issues was important to the participants.

The amount of physiotherapy most commonly concerned participants who felt that they had not attended enough sessions. However, some participants did feel that their input had been ‘just right’. The latter had their expectations fulfilled and were highly satisfied with the outcome despite the

duration being no longer than that for the other participants. This might suggest that the process and outcome are perhaps more important factors than the duration or frequency of treatment. However, there was a recurrent theme of participants perceiving that their physiotherapist was rushed and that they would ideally have liked more time with the physiotherapist:

‘I think I would have liked maybe a little more time doing exercises with them. . . rather than. Because it is very rushed in there it’s a very busy unit, and maybe a little more time, maybe 10 minutes, 15 minutes of actually doing the exercises with them.’ (Participant 9, 62-year-old female)

‘I felt it was a bit too rushed, but, I didn’t blame her for that. You know I knew she had a time limit, you know. So that would probably be my only wish perhaps, would be to have it maybe double the time.’ (Participant 23, 48-year-old female)

Organisation was therefore perceived by participants as an important area of patient-centred care. Getting the amount of physiotherapy right from the patient’s perspective may be challenging but clearly involves communication and taking an individualised approach to care.

Discussion

Patient-centredness, from the perspective of these CLBP patients, is a complex combination of the following six dimensions: communication; individual care; decision-making; information sharing; the physiotherapist; and organisation of care. Effective communication is common to all dimensions, emphasising its importance. The results of this study revealed a number of dimensions of patient-centredness that may assist physiotherapists to better understand and manage CLBP patients. However, a larger study is required to confirm whether the proposed model has broader relevancy among the CLBP population. Nonetheless, these results give some insight into the dimensions that appear to be important to CLBP patients, and should help physiotherapists to manage this client group according to their needs and wishes.

The findings have the most in common with Mead and Bower’s model of patient-centredness, developed from primary care literature [9] as shown in Table 3. The dimensions ‘individual care’ and ‘the physiotherapist’ from the current findings relate well to the dimensions ‘patient-as-person’ and ‘doctor-as-person’, whilst ‘decision-making’ from the current findings relates to ‘sharing power and responsibility’. However, communication, information sharing and organisation of care are not separate dimensions in Mead and Bower’s model [9], despite their importance in the current model. Finally, the biopsychosocial perspective is a dimension in Mead and Bower’s model [9], but not in the current model, presumably because the current model was gener-

Table 3
Models of patient-centredness

Nursing [Gerteis <i>et al.</i> (1993)]	Occupational therapy [Law <i>et al.</i> (1995)]	Medicine [Mead and Bower (2000)]	Current study findings
1. Respect for patient's values and needs	1. Autonomy/choice	1. Biopsychosocial perspective	1. Communication
2. Co-ordination of care	2. Partnership/responsibility	2. Patient as a person	2. Individual care
3. Information, communication and education	3. Enablement	3. Sharing power and responsibility	3. Decision-making
4. Physical comfort	4. Contextual congruence	4. Therapeutic alliance	4. Information
5. Emotional support	5. Accessibility and flexibility	5. Doctor as a person	5. The physiotherapist
6. Involvement of family and friends	6. Respect for diversity		6. Organisation of care
7. Transition and continuity			

ated from the patient's perspective and therefore presented in their language. However, many of the areas discussed by the participants, such as 'wanting to be treated as a person not a number', would be incorporated in a biopsychosocial approach to CLBP management. The findings suggest that although similarities with primary care medicine are present, patient-centredness in a physiotherapy context and from the patient's perspective should incorporate communication, information sharing and organisation as well as the dimensions it has in common with Mead and Bower's model.

The importance of communication was highlighted in this study, consistent with previous studies [2,3]. Several authors have suggested that healthcare practitioners need to improve their communication skills in order to deliver effective patient-centred care [2,13]. Previous studies have suggested that physiotherapy patients are dissatisfied with their lack of involvement in decision-making [11]. However, in the current study, the participants did not generally want to be actively involved in the decision-making process, provided that adequate information was well communicated. Perhaps this is the 'dialogue-centred care' suggested by Olesen [27], but more research is required to fully understand the importance of decision-making within the physiotherapy context and what it means for patient-centredness. Taken with the other findings, at the very least, physiotherapists should assess each patient's desire for involvement in decision-making and tailor their approach accordingly. This study found that organisation was an important dimension, discussed by almost all of the participants despite its absence as a specific interview question. This is consistent with Potter *et al.* [2] who found that private clients ranked organisation highly when describing a 'good' physiotherapist. It is topical that participants wanted direct access to physiotherapy, given recent research [17] suggesting that it may be feasible to provide such a service. The finding that participants wanted more physiotherapy could be interpreted as a need for more or longer sessions. However, participants who were most satisfied with physiotherapy in general included some that received few or short sessions. Other participants felt that the physiotherapist was rushed, and since lack of time can be interpreted by patients as lack of interest in them [11], what happens in the physiotherapy session may be more important than its duration or the number of sessions received. This research

suggests that adopting a patient-centred approach, incorporating the six dimensions presented in this paper, may enhance even a short consultation and lead to patient satisfaction.

Limitations

Generalisation

It is not the purpose of qualitative research to generalise to the wider population, but to demonstrate that findings 'can be transferred and may have meaning if applied to other individuals, contexts and situations' [28]. Therefore, it is intended that the current research has been presented in a sufficiently detailed manner for the reader to judge to what extent the findings apply in similar settings [29]. The views of a small group can never represent the 'truth', and further research is required to both confirm the findings of the current study, and establish to what extent the perceptions reported are present in other groups of CLBP patients [30]. Further research is also required to gauge the extent to which these findings relate to other patient groups attending physiotherapy, but there are likely to be close similarities. The self-selection of participants is a possible limitation of this study, as the views of particular groups may not have been recorded. This is difficult to overcome since self-selection is an unavoidable part of ethical research [30]. However, a range and contrast of views were expressed and incorporated in the present model, so the effects of this potential bias appear to be minimal. The fact that participants were being interviewed by a physiotherapist about their physiotherapy experience may have affected the outcome of the study. Steps were taken to limit this; i.e. the researcher did not wear uniform, she introduced herself as 'the researcher' on the day of the interview, and physiotherapy departments were not used to conduct the interviews. However, for ethical reasons, when asked directly, the researcher did disclose the fact that she was a physiotherapist and this information was also provided on the letter inviting the participants to take part. However, this knowledge did not prevent negative viewpoints about physiotherapy from being disclosed, and the participants presented a wide range of views.

Implications

An evidence-based model of patient-centred physiotherapy is presented for the first time. Addressing these dimensions of patient-centredness should enhance the experience of physiotherapy for CLBP patients. Physiotherapists should be aware of the six dimensions that are of importance to patients, paying particular attention to communication. Improving physiotherapists' communication skills may better facilitate patient-centred physiotherapy in this client group. Further research is required to explore the relevance of this model of patient-centredness in the wider CLBP population, and to evaluate patient-centred physiotherapy.

Key messages

- Communication, individual care, decision-making, information sharing, the physiotherapist and organisation appear to be important dimensions of patient-centred care, from the perspective of CLBP patients.
- Communication is the most important dimension of patient-centred physiotherapy for CLBP, and improving physiotherapists' communication skills may enhance patient-centredness.

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References

- [1] Scottish Executive. Delivering for health. Edinburgh: Scottish Executive; 2005.
- [2] Potter M, Gordon S, Hamer P. The physiotherapy experience in private practice: the patients' perspective. *Aust J Physiother* 2003;49:195–202.
- [3] Trede FV. Physiotherapists' approaches to low back pain education. *Physiotherapy* 2000;86:427–33.
- [4] Gillespie R, Florin D, Gillam S. How is patient-centred care understood by the clinical, managerial and lay stakeholders responsible for promoting this agenda? *Health Expect* 2004;7:142–8.
- [5] Maniadakis N, Gray A. The economic burden of back pain in the UK. *Pain* 2000;84:95–103.
- [6] Laerum E, Aage I, Skouen JS. What is the good-back consultation? A combined qualitative and quantitative study of chronic low back pain patients' interaction with and perceptions of consultations with specialists. *J Rehabil Med* 2006;38:255–62.
- [7] Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL. *Through the patient's eyes: understanding and promoting patient-centred care*. San Francisco: Jossey Bass; 1993.
- [8] Law M, Baptiste S, Mills J. Client-centred practice: what does it mean and does it make a difference? *Can J Occup Ther* 1995;62:250–7.
- [9] Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med* 2000;51:1087–110.
- [10] Payton OD, Nelson CE. A preliminary study of patients' perceptions of certain aspects of their physical therapy experience. *Physiother Theory Pract* 1996;12:27–38.
- [11] Harrison K, Williams S. Exploring the power balance in physiotherapy. *Br J Ther Rehabil* 2000;7:355–61.
- [12] Payton OD, Nelson CE, Hobbs MS. Physical therapy patients' perceptions of their relationships with health care professionals. *Physiother Theory Pract* 1998;14:211–21.
- [13] Ostlund G, Cedersund E, Alexanderson K, Hensing G. It was really nice to have someone...lay people with musculoskeletal disorders request supportive relationships in rehabilitation. *Scand J Public Health* 2001;29:285–91.
- [14] Scottish Executive Health Department. Partnership for care. In: Scotland's health white paper. Edinburgh: Scottish Executive; 2003. Available at: www.scotland.gov.uk/Publications/2003/02/16476/18730. Last accessed 26 September 2006.
- [15] Resnik L, Jensen GM. Using clinical outcomes to explore the theory of expert practice in physical therapy. *Phys Ther* 2003;83:1090–106.
- [16] Ritchie J, Lewis J, Elam G. Designing and selecting samples. In: Ritchie J, Lewis J, editors. *Qualitative research practice. A guide for social science students and researchers*. 1st ed. London: Sage Publications; 2003. p. 77–108.
- [17] Holdsworth LK, Webster VS, McFadyen AK. Self-referral to physiotherapy: deprivation and geographical setting. Is there a relationship? Results of a national trial. *Physiotherapy* 2006;92:16–25.
- [18] International Association for the Study of Pain. Classification of chronic pain syndromes and definitions of pain terms. *Pain* 1986;(Suppl. 3):S1–226.
- [19] Von Korf M. Studying the natural history of back pain. *Spine* 1994;19(Suppl. 18):2014S–46S.
- [20] Kappa EH, Frantsi K, Sarna S, Malmivaara A. Multidisciplinary group rehabilitation versus individual physiotherapy for chronic nonspecific low back pain. A randomised trial. *Spine* 2006;31:371–6.
- [21] Jousset N, Fanello S, Bontoux L, Dubus V, Billabert C, Vielle B, et al. Effects of functional restoration versus 3 hours per week physical therapy: a randomized controlled study. *Spine* 2004;29:487–94.
- [22] Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, editors. *Analyzing qualitative data*. London: Routledge; 1994.
- [23] Tobin GA, Begley CM. Methodological rigour within a qualitative framework. *J Adv Nurs* 2004;48:388–96.
- [24] Ritchie J, Spencer L, O'Connor W. Carrying out qualitative analysis. In: Ritchie J, Lewis J, editors. *Qualitative research practice*. 1st ed. London: Sage Publications; 2003. p. 220–62.
- [25] Barbour RS. Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *BMJ* 2001;322:1115–7.

- [26] Richards L. *Handling qualitative data. A practical guide*. London: Sage Publications; 2005.
- [27] Olesen F. Striking the balance: from patient-centred to dialogue-centred medicine. *Scand J Prim Health Care* 2004;22:193–4 [Editorial].
- [28] Finlay L. 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. *Br J Occup Ther* 2006;69:319–26.
- [29] Mays N, Pope C. Qualitative research in health care: assessing quality in qualitative research... first in a series of three articles. *BMJ* 2000;320:50–2.
- [30] May SJ. Patient satisfaction with management of back pain. Part 2: an explorative, qualitative study into patients' satisfaction with physiotherapy. *Physiotherapy* 2001;87:10–20.

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