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Exploring the older patient / physiotherapy clinician relationship

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ABSTRACT

FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES
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Doctor of Philosophy

EXPLORING THE OLDER PATIENT / PHYSIOTHERAPY CLINICIAN RELATIONSHIP

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This thesis seeks to explore and unpick the essence, rationale and role of the therapeutic relationship that occurs between physiotherapy clinicians and their older patients. To address the rehabilitation needs of the increasing ageing population, a strong evidence base for both the clinical and non-clinical components of the encounter is required.

A social constructivist approach was used within a sociological paradigm to explore this. Grounded theory method informed the sampling process and was used to analyse the data. Following a pilot study, two studies explored the experiences and perspectives of physiotherapy clinicians and older patients through semi-structured interviews and early models were devised. A final study observing individual treatments and interviewing the participants clarified, developed and tested these models.

Participants agreed that a relationship existed alongside, because of and time limited by the intervention, it being an important part of the physiotherapy encounter. The relationship has professional, human and intrinsic components brought to it by both parties and the service. Participants, usually unwittingly, play dual roles in the relationship. The physiotherapy clinician plays both professional role to direct treatment and a befriender role to humanise the experience for the patient. Older patients adopt a compliant "sick" role legitimising their illness and willingly submitting to treatment. However, the current health and societal push towards partnership means that the role of partner is imposed on the older patient. This attempts to narrow the traditional separation of clinician and patient dictated by professional hierarchy with a move towards equality, something that the older patients appear to neither understand nor want. There is potential for conflict within and between these roles which clinicians and older patients manage in different ways. The concept of equality in health care is alien to older people and undermining the power differential in the clinical situation may remove the one predictable element in an otherwise perplexing setting. The findings are possibly limited to the cohort effects of an older population and medium to long-term rehabilitation.

This thesis contributes to an understanding of the role of this relationship within the physiotherapeutic encounter. The possible implications for physiotherapy education and service delivery are discussed.

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Chapter One

Exploring Therapeutic Relationships in Elder Rehabilitation

1.1 The Research Question

This research seeks to explore therapeutic relationships in elder rehabilitation. In particular it seeks to unpick the essence of the relationship that develops between physiotherapy clinicians and their older patients and explore those factors that affect its formation, development and impact. These factors, including the role of the relationship in the delivery of and engagement with physiotherapy and the perceived impact on outcome, are explored from the perspectives of both physiotherapy clinicians and older patients receiving rehabilitation in day hospital and domiciliary settings. No attempt is made to compare the views of the participant groups; rather this thesis seeks to explore the essence of older patients' and physiotherapy clinicians' mutual experience of the therapeutic relationship through an understanding of their views and perceptions. Grounded theory method is used to explore this topic.

This topic arose from personal, professional experience of working in older person's physical rehabilitation, informal observation of physiotherapists working with their older patients, teaching an ageing and healthcare module to undergraduate physiotherapy and occupational therapy students, an interest in outcome measurement and a lack of specific literature in the field of physiotherapy clinician/older patient relationships. Current physiotherapy research is very much geared to the *science* born of evidence based practice and this topic had the capacity to explore the *art* of physiotherapy through an examination of its human interface.

The research question developed over time. The initial interest focused on an exploration of the non-clinical influences on clinical outcome in older patients. As this topic was too vast, it was gradually refined to explore the impact of the physiotherapy clinician/older patient relationship on outcome. However, literature in this specific area was found to be sparse and mostly anecdotal. Therefore the research question was expanded to explore whether this anecdotally reported relationship does in fact exist, and if it does, what does

it comprise, what role does it play, how is it perceived by both parties and what is its role and impact.

This is an important question as the demographic shift has the potential to increase the number of older people requiring physiotherapy rehabilitation and NHS (National Health Service) funding is constantly under pressure. Despite the priorities set in the National Service Framework for Older People (Department of Health, 2001a) which include promoting older person's health and independence, physiotherapy clinicians are required to optimise the efficiency and effectiveness of their intervention and reduce the length of the episode of care where possible. Evidence based practice is having an impact on the clinical management of older patients but the role of non-clinical factors such as the clinician/patient relationship in this field is little understood. My role as an educator of undergraduate physiotherapy students has highlighted the importance of encouraging them to address all the factors that have the potential to optimise the rehabilitation of older people. As NHS priorities change and resources become ever more stretched, it is vital that physiotherapy clinicians use every appropriate means to do this.

1.2 Research Support

This research was funded by an NHS South East Research Training Fellowship and supervised by Dr Rose Wiles, School of Health Professions and Rehabilitation Sciences and Professor Peter Coleman, Departments of Psychology and Geriatrics, both at the University of Southampton.

1.3 The Structure of the Thesis

This document starts by setting the scene against which the research was undertaken. It identifies the role of the physiotherapist in older person's medicine and the structure of the Health Service in which they work. It includes the significant changes in Trust organisation that influenced the way in which data was gathered and possibly, to some extent, the nature of the participant responses. The document continues with a literature review that explores ageing and the management of older peoples' health needs in the National Health Service. It continues by outlining the current thinking around

therapeutic relationships between health care professionals and their patients. The methodological rationale and methods chapter considers the philosophical basis, academic and practical issues of this research and includes details of the pilot study. The experiences and perceptions of physiotherapy clinicians regarding the relationships they form with their older patients are reported and discussed in Chapter 4. Some early models of the role and constituents of the relationship are put forward. These are developed further in Chapter 5 where the perceptions and experiences of older patients are considered. Another model relating to levels of engagement within the relationship is mooted. Four individual studies observing single treatment sessions followed by interviews with the participating physiotherapists and older patients are reported in Chapter 6. This chapter sets out the testing, relevance and adaptation of the previously identified models and proposes the core concept of this research. These models and core concept are discussed in Chapter 7, returning to the literature to develop the arguments. The practical and academic limitations to the study and reflections on researcher impact, data analysis and interpretation are included in each findings chapter (Chapters 4, 5 and 6). Finally, the Conclusions chapter revisits the research question and considers the professional and academic implications of this research.

1.4 **Physiotherapy and Physiotherapists**

Physiotherapy is defined as "A health care profession concerned with human function and movement and maximising potential, using physical approaches to promote, maintain and restore physical, psychological and social well-being" (CSP, 2002a). This includes the rehabilitation of older people. Within the UK, physiotherapists are permitted to work within the National Health Service if they qualify for membership of the Health Professions Council (HPC). The most common route is through obtaining a UK undergraduate degree in physiotherapy that is validated by the UK professional body, the Chartered Society of Physiotherapy (CSP). Physiotherapy in the United Kingdom has only been an all graduate entry since 1992 and there are many physiotherapists working within the NHS who obtained their professional qualification of a graduate diploma prior to this. The diploma was instigated and examined by the professional body and success permitted membership to the Chartered Society of Physiotherapy, allowing diplomates to

call themselves chartered physiotherapists. Alongside other allied health professions such as podiatry, despite many years of lobbying, there was no legal closure within the profession and anyone in the UK could set him or herself up as a physiotherapist. It was only when the Health Professions Order 2001 came into effect in July 2003 that the term physiotherapy became a protected title. Up until then (and encompassing the period of this research) the distinction of chartered physiotherapist was important to those clinicians, as it was an automatic passport to state registration through the Council for Professions Supplementary to Medicine which went on to be replaced by the Health Professions Council. Graduate physiotherapists qualifying in other countries and fulfilling the criteria for HPC registration are also able to work within the NHS. Although strictly speaking the term state registered physiotherapist has not been necessary since 9th July 2003, it is occasionally used in this thesis as the research was undertaken before this time and therefore the term was liable to be employed by participants.

The career structure for chartered physiotherapists within the NHS starts at a junior position (also historically known as basic grade) available straight after qualification and registration. Junior posts are generally rotational, with the physiotherapist moving between different areas of inpatient, outpatient and sometimes community care within the employing Trust every four months to gain general experience. Promotion to a senior two position is usually sought at around two years post qualification. These positions are also rotational, often six monthly. Most are general posts although, in larger NHS Trusts, some senior two posts are offered within specialities. The next grade up is Senior one. Senior one posts are based in single specialties and demand considerable clinical experience in the field. Senior one physiotherapists are often also responsible for managing a small team of physiotherapists and physiotherapy assistants and may act as clinical supervisors for students. Superintendent physiotherapists often continue to have a clinical as well as a managerial role, heading up a department that is speciality, and sometimes also geographically, determined. Physiotherapy managers have responsibilities for several physiotherapy teams, departments and / or geographical areas. There are various grades of superintendent and manager determined by staff group size

and managerial responsibility. A relatively new post of clinical specialist can be given to a senior one or superintendent physiotherapist with proven clinical expertise in a specific area. In older person's medicine these posts may be given to physiotherapists with expertise in stroke, Parkinson's disease or falls. Higher clinical grades of consultant physiotherapist are now starting to emerge within the NHS. Now that NHS Trusts are able to negotiate their own contracts with staff the grading criteria can differ slightly between Trusts.

Physiotherapy assistants do not have any physiotherapy qualifications although many have NVQs (National Vocational Qualifications) relating to health and caring. The role of the assistant is to support the physiotherapist. In the past this was limited to domestic duties keeping the department clean and tidy and assisting physiotherapists where two people were required to mobilise patients. Now, physiotherapy assistants have enhanced status enabling them to become assistant members of the Chartered Society of Physiotherapy. They work alongside physiotherapists, undertaking exercise programmes prescribed by their qualified colleagues. Many manage their own workload, reporting back to their qualified colleague as required. Some physiotherapy assistants in the Trusts participating in this research were deemed experienced enough to undertake basic assessments and adapt exercise programmes as circumstances dictated. In some Trusts there is a two tier grading system for assistants based on their NVQ qualifications and experience.

In this thesis the term physiotherapist is used to denote a qualified, state registered physiotherapist. All the physiotherapists participating in this research had qualified in the UK and were members of the Chartered Society of Physiotherapy. The term physiotherapy assistant relates to both grades of assistant and denotes someone who works alongside and under the direction of a qualified physiotherapist. The term physiotherapy clinician encompasses both designations.

1.5 NHS Local Service Changes during the Period of the Study

The Labour government set out their NHS reforms within the first year of their first term in office in 1997. The New NHS, Modern Dependable (Department of Health, 1997) outlined new organisational plans that built on the Trust structure first enacted by the Conservative government in the early 1990s. This white paper reversed the old strategy of centralised management and set out plans for management through primary care services being "a system based on partnership and driven by performance" (Department of Health, 1997). Over the succeeding years large community and specialist Trusts have reorganised to spawn primary care groups controlling unified budgets, delivering health care to communities averaging one hundred thousand people (Wilkin et al 2001). Seventeen of these groups achieved Trust status in April 2000 having full control of their budgets and managing community health services as well as commissioning hospital care on behalf of their patient population. All primary care groups are expected to achieve Trust status by 2004.

This study was undertaken in Chichester and Portsmouth against the background of these changes. Inpatient and day hospital services for older people in the Chichester area are provided by the Royal West Sussex NHS Trust from St Richards's Hospital (acute services) and the Munro Unit (elderly day hospital services). Community and domiciliary services are supplied by the sister community Trust. Physiotherapy services are managed and funded by the two Trusts. This has remained unchanged during the period of this research. In contrast, all NHS physiotherapy services in the Portsmouth area prior to April 2001 were managed and funded through the Portsmouth Healthcare NHS Trust. At this time health care in the Portsmouth area was supplied by two NHS Trusts. Portsmouth Hospitals NHS Trust provided all acute hospital inpatient and outpatient services and purchased all their physiotherapy requirements from the Healthcare Trust that provided community, domiciliary and specialist non-acute services. Thus older patients moving from acute to day hospital and then community and domiciliary physiotherapy in the Portsmouth area remained within the management of one Trust whereas in Chichester older patients moved between Trusts as they left acute and day hospital services and were referred to community care.

In April 2001, health services in the Portsmouth area were substantially reorganised. Portsmouth Healthcare NHS Trust effectively split into two new primary care Trusts (Portsmouth City Primary Care NHS Trust and East Hampshire Primary Care NHS Trust) and one primary care group (Fareham and Gosport Primary Care Group). These new services are geographically determined and although the Portsmouth Healthcare NHS Trust still existed to provide mental health and other specialist services it ceased to be a trust in April 2002 when other providers took on these duties. With this reorganisation, the physiotherapy services previously delivered and managed under the Healthcare Trust split into separate Trust/Group management. This led to a reorganisation of older person's physiotherapy services that, at the time of the physiotherapy clinicians' study, were provided only by the two primary care Trusts and one primary care Group.

At the time of the pilot and physiotherapy clinicians' studies, the following providers offered older persons' physiotherapy services in the geographical area under investigation:

Royal West Sussex NHS Trust:	Munro Day Hospital (Chichester)
Portsmouth City Primary Care NHS Trust:	Amulree Day Hospital (City)
	Trevor Howell Day Hospital (QAH)
	Rembrandt Unit (intermediate care)
	Community Rehabilitation Team (City)
	Domiciliary Physiotherapy (City)
East Hampshire Primary Care NHS Trust:	Laurel Day Hospital (Petersfield)
	Community Rehabilitation Team
	Domiciliary Physiotherapy (W'ville)
	Domiciliary Physiotherapy (Havant)
	Domiciliary Physiotherapy (P'field)
Fareham and Gosport Primary Care Group:	Dolphin Day Hospital (Gosport)
	Community Enablement Service

By the time of the older person's study, the Fareham and Gosport Primary Care Group had become a full NHS Trust.

The Portsmouth services have undergone significant changes in staffing with relatively junior, inexperienced staff being promoted to senior and managerial positions in the new trusts/group. The previous physiotherapy manager of older persons' services for the Portsmouth Healthcare NHS Trust negotiated cross trust/group in-service training and rotations for junior and senior two staff in line with current clinical governance thinking. Whilst this has retained a common approach to service delivery at a professional level service delivery has changed criteria that now differ between service providers. The process of discussing the future management of elderly medicine to ensure quality and parity of provision and care in the Portsmouth area is continuing. During the period of this research the staff in Chichester also changed. The senior physiotherapy manager changed twice and the superintendent and senior one physiotherapists retired. These posts were transferred to the acute elderly in patient and stroke services to accommodate the requirements of the National Service Framework for Older People, leaving a limited outpatient service available in the Day Hospital. The way in which these changes influenced the research is discussed in later chapters (3.7.1.2; 4.7.1; 5.7; 7.3).

1.6 Summary

This thesis explores the relationship that develops between physiotherapy clinicians and older patients undergoing medium to long-term rehabilitation physiotherapy. This research was undertaken in two adjoining geographic areas in the South of England. The thesis chapters are set out chronologically and include the background literature, methods, findings and discussion. The career structure of physiotherapy within the NHS and the background to service changes within the participating NHS Trusts inform the practical and theoretical exploration of the research topic.

Chapter Two

Therapeutic Relationships: exploring the literature

2. Introduction

This chapter reviews the literature around the topics of ageing, the health services available for older people and the ways in which society and current government policy is addressing the health care needs of the increasing older population. Sociology and epidemiology literature was accessed through Winspirs. Key words ageing, old age and older people were used and cross referenced with other key words demograph*, health, healthcare, rehabilitation and geriatric*. The search was extended to Medline, Embase, Cinahl and ISI Web of Science (1982 – present). In addition, hand searches were undertaken of books and journals relating to older people, sociology and ageing, sociology and health, health psychology (mid 1990s to present, see Appendix 1.1). Some other references snowballed from the papers identified here.

The literature on ageing and healthcare sets the scene for the second part of the review that considers the therapeutic relationship between older patients and health care professionals, its definitions, components and the differing ways it is viewed and constructed by different professions. In particular literature exploring the relationships that clinicians, including physiotherapists, develop with their older patients is identified and discussed. Electronic searches of Medline, Cinhahl and Embase (1982 – present) were undertaken using key words therapeutic relationship, doctor-patient relationship, caring relationship. Cross-links were made with other key words: nursing, physiotherapy, medicine, doctor, occupational therapy, psychotherapy, counselling, attitudes, beliefs, and communication. An Internet search (Alta Vista and Google) was conducted using the term therapeutic relationship. Other relevant literature was identified by supervisors and colleagues and from conference and seminar presentations.

The initial search was undertaken in Autumn 2000 and updated in April 2003. Other relevant literature was gathered through regular trawling of new issues of medical, nursing and physiotherapy journals and through monthly Zetoc updates relating to

appropriate sociology, psychology, anthropology and relationship academic journals (appendix 1.1).

Grounded theory method was used to explore the topic of older patient / physiotherapy clinician relationships. A characteristic of this method is in the extent to which the literature is explored early on in the research. Strauss and Corbin (1998a: 49) caution against the researcher becoming "so steeped in the literature that he or she is constrained and even stifled by it". However they concede that a certain amount of background knowledge is required to enhance the data collection. This study has followed these guidelines with the initial literature searches into ageing and healthcare services in the United Kingdom and a review of the therapeutic relationship as perceived by health clinicians. These reviews are presented in this chapter and outline the historical background, current need and level of health services for older people and recent research into therapeutic relationships. These topics were chosen to sensitise the researcher to the issues without compromising the findings and interpretation of the research. These reviews also assisted in identifying that there was a question to be answered that was relevant to physiotherapy and informed the early interview guides. However, as the research and analysis continued it became clear that some topics identified in the initial literature review such as professional power and partnership needed to be explored further and new topics such as role, equality and befriending needed to be investigated. Thus new literature searches were undertaken and are included in later chapters as part of the discussion of findings in line with the grounded theory approach.

2.1 Ageing in the United Kingdom

2.1.1 Definitions of Ageing

Old age is defined in various ways and from a variety of differing perspectives. Biologically, it is defined as physiological senescence, the increasing frailty of the body systems that occurs naturally as the organism ages (Kirkwood, 2002). Sociologically, old age is defined as a mechanism for social differentiation being culturally determined and relating to the latter part of the life course (Vincent, 2000). Bytheway (1995: 128) would

prefer old age to be defined as pertaining to "pretty ordinary people who have lived long lives and survived many experiences".

Such general definitions bear little relation to the more commonly used definition of pensionable age (Tinker, 2002). Sixty five years, whilst a chronological age that is neither an accurate indicator of physical function, social engagement nor financial status, is recognised in the UK as the usual retirement age (Fennell et al, 1988). Thus government departments use it as an indicator of having reached old age and entitlement to state pensions and benefits. The National Health Service categorises patients as elderly once they reach 65 years and a whole range of "geriatric" and health promotion services open up for these people (DoH, 2001a) including flu vaccination and health screening. Many industrialised countries accept that people in their sixties and seventies will not make significant demands on health services and have created two categories of older age, 60-74 years being "young old" and people of 75 years being "old old", concentrating their health care provision in the older age group (Ebrahim, 1999).

2.1.2 Demographics of Ageing in the United Kingdom

It is widely recognised that the ageing population is a worldwide phenomenon (Tinker 2002). Within the United Kingdom it is projected that the number of people aged 60 years and over will increase from 12 million in 2001 to 18.6 million in 2031 (Government Actuary's Department, Office for National Statistics, 1999). This represents an increase from 20% to 30% of the entire UK population (Khaw, 1999). Ebrahim (1999) concludes that of the current UK population "Most of us will see our 85th birthday, but unfortunately for a quarter of us, that will be through the haze of a dementia syndrome or some other chronic disease or disability". Bone et al (1995) project that, based on the 1976 prevalence figures, the number of people aged 65 years and over unable to perform four basic, personal activities of daily living (transferring from bed, bathing, getting to the toilet and feeding) will rise from 1.7 million in 1996 to nearly 3.5 million in 2051. However, these figures are disputed by Grundy (1997) who, working from 1991 projections, predicts a rise from 0.5 million in 1996 to 1 million in 2036. Arber (1998) too argues that since 1981 the proportion of people aged over 65 years, with

and without recorded health care needs, has remained constant at 16% and was actually projected to fall at the turn of the 21st century, rising again to 17% by 2011. It is certain, however, that as the post war baby boomers become the young pensioners of 2020 and the number of old, old people rises substantially as life expectancy increases, the proportion of younger people of working age available to provide care for the old is falling (Vincent, 2000). Khaw (1999) predicted that by 2015, the relative proportions of old people and children 16 years and under would be roughly equal and that thereafter, people over 65 would outnumber children. In fact, figures from the 2001 UK Census revealed that there were already more over 60s (21% of the total population of England and Wales) than there were children under 16 (20%) (Office for National Statistics, 2003). Across the European Union between 1995 and 2000 there was a 12.6% increase in employment growth in the health and social care sector (Watson, 2001). It is unlikely that this rate could be sustained in the face of increasing social and health care need.

2.1.3 Responding to the Demographic Changes

Responses to this demographic shift vary between commentators who perceive differing impacts on society. Many believe that the increasing numbers of older people will be reflected in a massive increase in the need for health and social care services and warn of a time bomb of need that western governments must address with speed (Young et al, 1998; Khaw, 1999; Tonks, 1999; Heath, 2000; Young and Philp, 2000;). An alternative view suggests that as medical care evolves, the healthy period of life will increase such that "the period of morbidity could potentially be compressed into the brief interlude between 85 years and death" (Fries, 1980). The Royal Commission on Long Term Care (1999) similarly concluded that the same factors that allow us to live longer are also resulting in extra years being free from disability. In 1991, in England and Wales, healthy life expectancy at age 65-74 years was 7.9 years for men and 9.8 years for women – about half their remaining life expectancy, indicating that old people could expect significant health limitations of around 8 years for men and 10 years for women at the end of their lives (Bone et al, 1995). Improvements in health promotion and disease prevention in old age are felt by Andrews (2001) to show evidence of a healthier aging population to which Vincent (1995) adds peace and better nutrition (p130). Vincent

(2000) also writes of the effect of social changes in the established life course pattern allowing a significant number of fit, healthy "young old" to retire free from the shackles of financial burden with good pensions and paid-up mortgages. Changing labour markets and migration patterns allow these people to take on voluntary jobs, even new careers, a return to education or a new life style abroad. The increasing numbers of "young old" are becoming a political force, demanding notice from the government concerning their views on pensions and health care.

2.1.4 Addressing the Demographic Changes

Understandably, the response to these two arguments has been a degree of confusion. Clearly the older population is increasing but is the health and social care burden increasing at the same rate? Laslett (1978) argues that "20th century Britain, along with other Western societies, has a guilty feeling about the elderly, uneasily suspecting that millions of old folk live in reduced circumstances, not much cared about by such children and kin as they have left to them, solitary and, as they grow more aged, miserably relegated to institutional living" (p 6). Since the late 1990s a flurry of reports has been commissioned to investigate this potential "burden" and explore possible solutions but this has done little to clarify the issues. One of these, The Royal Commission Report, explored the funding of long-term care for the elderly (1999). Findings recommended the establishment of a national care commission to monitor trends, costs and accountability, something welcomed by some clinicians and academics who saw it as a means of building a workable and constructive strategy for good, long term elderly care (Bowman et al, 1999). However, others felt that, as with a similar Royal Commission report of a century earlier, this also lacked the revolutionary and creative thinking that would challenge inequalities and address the needs and wants of older people in a changing social world (Murphy, 1999). One of the recommendations of the 1999 Royal Commission was the splitting of nursing care from non-nursing needs for people living in nursing homes. The delay in the implementation of this – it finally happened two years later in October 2001 (DoH, 2001b) - was considered a "dereliction of duty" by Heath (2000). Heath, a general practitioner, argued that when men living over 65 years had a one in five chance and women a one in three chance of needing residential care,

implementation of the recommendation would "dismantle the Berlin Wall between health and social care". She castigated the government for its tardy response suggesting the delay was politically expedient. Such views identify the impatience of some clinicians with the policies that are affecting their practice.

Problems of elderly people being seen as "bed blockers" and being treated as second-class citizens have led to accusations of institutional and individual ageism inherent in health service providers (Bullock, 2000; Lothian and Philp, 2001). Bytheway (1995) defines ageism as "a process of systematic stereotyping of and discrimination against us when we are considered old" (p128). Norman (1987) believes ageism is due to looking for the problems in the old people rather than the society that claimed to care for them. French, writing in 1990, felt that physiotherapists showed ageist attitudes through their use of ageist language and working within a medical model. A decade later, newly qualified physiotherapists were found to be consciously trying to avoid ageist behaviour in their attitudes and approach, although where some physiotherapists did show social stereotypical views towards their older patients as they started their careers, these changed only to become clinical stereotypes a year later (Barnard, 2001).

In response to the growing dissatisfaction of clinicians with the management of older patients and the influence of the growing older population, The Department of Health published the National Service Framework for Older People (2001a). This had a two-fold aim. Firstly it promised a move away from age discrimination in accessing health services including the provision of person centred care, promoting health and independence. Secondly it set out standards for addressing some of the key health problems of older people including falls related problems and stroke, aiming to mitigate some of the main disabling factors of older age through intensive and co-ordinated prevention and rehabilitation programmes. As well as service delivery changes, tackling negative attitudes through training of health care professionals is also seen as a priority (Lothian and Philp, 2001). Although it is acknowledged that the guidelines in this Framework will take time to become established, a report by Help the Aged (2002) found that although age discrimination in the NHS had been acknowledged by the government,

it was still endemic across public institutions and that discrimination on grounds of age alone still existed within health services. Not everyone has greeted the National Framework with wholehearted enthusiasm. Grimley Evans and Tallis (2001) suggest that the Framework has a "split personality" arising from the differing agendas of the experts who advised on its content and the civil servants who wrote it. They fear that confusion will arise in the implementation as NHS trust managers follow the authors whilst clinicians will be wanting to endorse the good intentions of the advisors.

2.1.5 The Evolution of Health Services for Older People

The spirit of The National Service Framework for Older People represents how far healthcare for older people has come since its inception as a specialism in its own right in 1935. Prior to this time, physicians such as Cheyne and Charcot had specifically studied diseases of later life in the 18th and 19th centuries. Ignatz L Nascher, a Vienna born immigrant to the United States of America coined the term "geriatric" meaning the medicine of old age in 1909 (Grimley Evans, 1997). Although this stimulated interest in social and biological research into ageing, it was not until Dr Marjory Warren initiated the assessment and rehabilitation of several hundred old people in the old workhouse wards of Isleworth Infirmary that the clinical speciality of geriatrics was born. Britain led the way in geriatrics with the newly founded NHS appointing consultant geriatricians within a few months of its inception in 1948. Although models of management and care within the specialism have varied over the past fifty years, mostly due to the internal politics of medicine and the health service, the principles of assessment and rehabilitation remain. Improvements in medical care have reduced length of hospital stay and, in some cases, specialist training of GPs and changing outpatient treatment protocols have removed the need for hospitalisation. These and changing government policy are moving non-acute health care into the community.

During this current government, health and social care for older people has become a priority exemplified by the appointment of a National Director of Older People's Services in 2000, colloquially known by the popular press as the Ageism Tsar (Frontline, 2000). The changing Department of Health terminology from "geriatrics" to "elderly medicine"

to "older persons' health and social care" may represent politically correct spin but it also reflects the changing priorities and understanding of older persons' needs and potential. The linking of health with social welfare recognises a long known association between health and social care, first identified in geriatric medicine by Dr Warren who noted that as well as some health problems being caused by social deprivation, some social problems were in fact the result of patients being poorly served by health services (Grimley Evans, 1997). The links between poor health and social deprivation were later published widely, significantly in government funded reports The Black Report and The Health Divide (Townsend et al, 1988). In the new century, Young and Philp (2000) see the future of geriatric medicine as including both health and social elements and developing to respond creatively to address the needs of older people as a priority. However, Ebrahim (2002) warns that although it is important to retain a certain amount of medicalisation of old age, that is, treating the treatable conditions rather than dismissing them as mere products of old age, medicine has little to offer the two commonest scourges of old age – poverty and loneliness.

2.1.6 Summary: Ageing in the United Kingdom

The demographic changes in the United Kingdom predict growing numbers of older people and although many will retain good health well into their retirement, many will have significant health care needs in the final years of their lives. These needs will have to be met by a reduced number of people of working age providing both the manpower and finances to address them. Already clinicians are under pressure to provide quality, effective health care in time and cost efficient ways. As episodes of care are reduced to maintain service delivery to all patients, clinicians are under pressure to provide evidence-based interventions to optimise this.

"Explanations of the ways in which medicine achieves therapeutic benefits are increasingly based on the isolation of discrete effects" (Fitzpatrick et al, 1983). With the advent of evidence-based practice this has never been truer. And yet the literature is full of references to the non-clinical elements that go into the healing process. Although the evidence base is growing for specific physiotherapeutic interventions (CSP, 1996-1997;

CSP, 1999-2001) there is little evidence for the role of the therapeutic relationship in rehabilitation and recovery. If every aspect of physiotherapy intervention is to be optimised, it is important that the role and potential value of the therapeutic relationship is also explored. The second part of this literature review explores the definitions, constituents and role of the therapeutic relationship in clinical interventions in older persons' health care.

2.2 Therapeutic Relationships

2.2.1 Definitions

The therapeutic relationship is described in a range of health professional literature including nursing, medical, physician assistant, psychotherapy and family therapy, occupational therapy, physiotherapy and complementary medicine. Each profession defines the therapeutic relationship in a slightly different way that reflects their professional role, although there is considerable overlap. As relatively little is written about the physiotherapy clinician / patient relationship and even less about that between physiotherapy clinicians and older patients the wider literature surrounding therapeutic relationships in health care was explored. The following section looks at the ways in which the different health care professions define this relationship and the different emphases that are placed upon the different components of the relationship. Also discussed is the way in which some of these definitions have evolved within the professions reflecting social and health service change.

2.2.1.1 Nursing

The nursing literature most commonly describes the therapeutic relationship in terms of the caring or nurse-patient relationship. Historically the role of the nurse was to deliver healthcare at the direction of the physician (Ramos, 1992) and the intimate nurse-patient relationship was seen as the vehicle for care-giving leading to recovery.

"The nurse should... attempt to ascertain, and if possible, to remove causes of worry, confusion, strangeness and discomfort that are hindering the progress of the patient.... The patient who is being made comfortable by an intelligent nurse has that confidence in her which makes him ready to accept her suggestions for his continued wellbeing."

(Tracy 1938 in Ramos 1992)

Other literature portrays the relationship as a "nurse-patient relationship" (Ramos, 1992; Jones et al, 1997; McQueen, 2000). This is described as having other components than just caring including communication skills (Daubenmire et al, 1978) interpersonal skills, personal attributes (Dyson, 1996; MacKintosh, 2000), "professional bonding" (Ramos, 1992) and psychosocial, professional and technical aspects (Lea et al, 1998). A full, concise definition of the nurse-patient relationship has not been identified.

NHS reforms in the late nineties led to a more patient directed approach to clinical care that has influenced practice and research across all clinical disciplines including nursing (Department of Health, 1997; Department of Health, 1998; Department of Health, 1999). McQueen (2000) considered the nurse-patient relationship in hospital care in the light of these changes. She notes that to ensure partnership, patients need information and explanation and that nurses are well placed to deliver this. To facilitate this, the formation of "a trusting professional relationship" is fundamental although she suggests that problems arise when this takes second place to "more observable nursing work" although these problems are not discussed.

The theme of patient partnership is taken up by Olsen (1997) who defines the nurse-patient relationship as "a positive connection to the patient as a person". Although the nurse caring theme is strong, the responsibility of the patient to participate fully and appropriately is identified as crucial and patients not adhering to this ideal are perceived as deviant.

It would appear that over the years the purely "caring relationship" in nursing has moved from a paternalistic, tending approach to a "nurse–patient relationship" which anticipates

a more (in theory at least) equally proactive partnership between individual nurses, patients and other healthcare professionals in which all parties have both rights and responsibilities. Whilst earlier writings report that the caring relationship is directly related to recovery (Tracy, 1938 in Ramos 1992), recent literature exploring the nurse-patient relationship is more concerned with patient satisfaction, autonomy and partnership than its impact on clinical outcome (Fosbinder, 1994; Jones et al, 1997; Patistea and Siamantra, 1999).

The development of nurse led units has highlighted the split between the continuing professionalisation of nursing with the identification of the extended nurse role – where the nurse moves towards being a substitute doctor, and the enhanced role – where nursing practice defines its own autonomy developing 'caring' rather than 'curing' nurse-patient relationships. However, a study by Wiles et al (2001) found that most nurses working in a nurse led intermediate care unit perceived their caring role in therapeutic nursing as requiring less skill, having less status and not something that would develop their careers. This suggests that the caring element of the nurse-patient relationship is less valued in the move towards a distinct, autonomous nursing profession.

2.2.1.2 Medicine

In defining the relationship that exists between doctor and patient issues of communication, ethics and professional power within the relationship are all acknowledged in the medical literature. This section looks at the way in which the medical profession perceive this relationship. Medical sociologists also consider the doctor patient relationship and this is discussed later in this chapter (2.2.3.4).

The therapeutic relationship in medicine is most commonly portrayed as a doctor/physician-patient relationship or doctor-patient encounter and is most commonly considered from the perspective of communication skills (Myerscroft and Ford, 1996; Lloyd and Bor, 1996) or medical ethics (McMillan, 1995).

Greene et al (1994) explore the role of communication in the doctor-older patient relationship that she describes as an "effective and mutually satisfying medical encounter". Ludwig (1999) describes the basis of the physician-patient relationship as being formed by the bond of trust between the patient and physician that is vital to the diagnostic and therapeutic process. She notes that the characteristics of this relationship are still evolving having their roots in the patient's dependence on his physician for the special skills of maintaining or regaining health and, since the latter half of the twentieth century, now evolving towards partnership in shared decision making. She describes this as a model that " respects the patient as an autonomous agent with the right to hold views, to make choices and to take actions based on personal values and beliefs".

McMillan (1995) has concerns with the move towards full equality in the doctor-patient relationship that he defines "as a form of partnership" and "different from other relationships [such as] to constitute an exception in which the physicians are justified in assuming responsibility for patients possessing decisional capacity". He quotes MacIntyre (1977) as describing the paternalistic and duty of care elements of the doctor-patient relationship. "To invite a doctor to treat you as a patient is, in certain respects, to invite him to take responsibility for you". McMillan debates the malpractice phenomenon that he considers has brought about an era of neo-paternalism, a physician centred paternalism in which physicians act first in their own interest. He argues that in such a climate for a physician to take control of the medical encounter "seems both a practical and a prudent requirement".

Dixon and Sweeney (2000) revisit the older concept of the bedside manner in general practice and complementary medicine. They see the "human factor" in the doctor-patient relationship as effective placebo, which in the past "elevated yesterday's doctors above other people" and today plays an important part in promoting self-healing. They ascertain the power of the doctor-patient relationship in that "such healing effects do not need to be mediated by an inert substance but can occur as a direct effect of the doctor-patient interaction". Complementary medical practitioners agree, concluding from complementary therapy research that the "non-specific aspects of treatment such as

mutuality, trust, care and challenge are actually central to healing" (Mitchell and Cormack, 1998).

Overall, apart from the more humanistic approach of Dixon and Sweeney (2000) the doctor-patient relationship is defined within a reductionist perspective. Whilst other authors identify the role of the relationship in patient compliance (Stewart, 1984; Ludwig, 1999), Dixon and Sweeney are alone in their assertion that the doctor-patient relationship impacts on outcome. Descriptions of the doctor-patient relationship appear to retain a personal distance not observed in the nursing literature. The move towards physician-patient partnership is being directed by changing government policy and cultural change although the implications of this are causing concern in the fields of medical ethics and litigation.

2.2.1.3 Psychotherapy and Family Therapy

The therapeutic relationship or therapeutic alliance is seen as the central tenet of psychotherapy practice, considered by some (Denes, 1980; Niolon, 1999) to be the precursor to the transference relationship. The actual relationship between therapist and client is seen to be more predictive of therapeutic process than any specific approach or technique (Vernon, 2000). Conte (1999), a proponent of Gestalt Therapy also notes that "the cure is really in the way in which the therapist "is" in the relationship". Niolon (1999) identifies the components of the therapeutic relationship in psychotherapy as being constancy of the therapist's interest no matter how disturbing the subject, suspension of moral judgement, empathy, insight, understanding and acceptance. He also identifies the importance of giving the patient the opportunity to speak the unspeakable and notes the need for reliability in the therapist to engender a sense of trust to allow himself to be used as a transference object. Newland (1997) developed a questionnaire to ascertain trauma survivors' experiences of the therapeutic relationship they had with their male therapists. The questionnaire is based around seven themes that Newland considers key to the therapeutic relationship: the development of trust, perceived competence of the therapist, perception of empathy, boundaries, feelings of empowerment, the working alliance and problem resolution.

It would appear that the therapeutic relationship in psychotherapy differs from those developed between other health professionals and their patients in that the relationship itself is the focus of the encounter rather than a vehicle for communicating and administering other treatments. However, the key components of self and clinical skill are common to all.

2.2.1.4 Occupational Therapy

Occupational therapy has spent much time examining the therapeutic relationship from their professional perspective partly as many occupational therapists work within mental health and counselling and therefore work within similar boundaries to those of psychotherapists. In addition, during the last two decades there has been a certain amount of soul searching within the profession as to its role and rationale. During this time much work was done exploring the profession's frames of reference and this included seminal works on the therapeutic relationships within occupational therapy.

Hagedorn (1995: 105) states that the therapeutic relationship is important in occupational therapy, as caring is the foundation of occupational therapy and occupational therapists are responsible for the delivery of best care. She describes the therapeutic relationship as that "special relationship between the person seeking help or healing and the person from whom that help is sought". Mosey (1986) defines this relationship as "a planned interaction with another person in order to alleviate fear or anxiety, provide reassurance, obtain necessary information, provide information, give advice and assist the other individual to gain more appreciation of and more functional use of his or her latent inner resources. Such a relationship is concerned with promoting growth and development, improving and maintaining function and fostering a greater ability to cope with the stresses of life." She states that this relationship is facilitated by the occupational therapist's "therapeutic use of self, the artful, selective or intuitive use of personal attributes to enhance therapy". She says that this differs from simple rapport with the patient, which she describes as "a comfortable, unconstrained relationship of mutual confidence".

Hagedorn (1995) considers that the relationship between patient and therapist can be a powerful agent for positive change noting that mutual trust and respect are crucial to the healing process and that the impact of this may be at least as curative as the prescribed therapy. Lloyd and Maas (1991) also consider that a good relationship between occupational therapist and patient contributes to the effectiveness of treatment. However, Hagedorn unlike the psychotherapists discussed above, rejects the possibility that it is the relationship alone that cures, stating that occupational therapy is "doing therapy" not "talking therapy".

The skills needed to build a therapeutic relationship in occupational therapy are seen to be those required for any effective communication (Hagedorn, 1995) including effective communication skills, empathy and education. Other components of the relationship noted by other commentators include respect for the individual patient's point of view, mutual co-operation, a level of therapist qualification and expertise (Lyons, 1994) and a set of professional values (Yerxa, 1983). Both Lyons (1994) and Hagedorn (1995) caution against becoming over involved with patients within the relationship noting the potential problems awaiting those therapists who overstep professional boundaries. However, they also identify a reduction in the therapeutic impact of the relationship where the therapist seeks protection from close involvement behind professional distance. Both Hagedorn and Lyons perceive this as occupational therapists being personally ill-equipped to deal with such situations rather than any fault in the system of service delivery or manipulation of the relationship by the patient.

Lloyd and Maas (1991) explored the development of the therapeutic relationship between occupational therapists and their patients. They consider it to evolve over time through various stages dependent on mutual communication, goal negotiation and the implementation, management and evaluation of the therapeutic intervention followed by closure.

Peloquin (1990) considers the occupational therapist–patient relationship from the patients' perspective seeing it as a collaborative relationship being "a blend of

competence and caring". She states the importance of the therapist understanding and taking account of the patients' needs, visions and expectations and describes some patients as "frustrated by an occupational therapist who does not demonstrate the kind of personal concern she wants and expects".

It is interesting to note that, alone amongst health professions defining the therapeutic relationship as being important and claiming to provide patient centred health care, only occupational therapy places the patient first when describing the encounter e.g. client – therapist relationship (Lyons, 1994), person seeking help and person providing that help (Hagedorn, 1995: 104).

2.2.1.5 Physiotherapy

Writing in 1969, Hailstone describes the role of the hospital ward physiotherapist. He noted that as well as "particular specialist skills" there is "the development of a two way emotional interaction" that allows the physiotherapist to see the patient as a person rather than the "femur in bed 12". Fifteen years later Gartland (1984) defined this relationship as "a therapeutic relationship: a means of communication wherein both [physio]therapist and patient interact to achieve a therapeutic goal". Williams and Harrison (1999) explored the components of such a relationship building on this definition to include honesty and collaboration with patients. They also noted the ethical, social, cultural and power relationship issues within the physiotherapist-patient encounter (see 2.2.3.4). Williams and Harrison describe the therapeutic relationship as the vehicle for clinical intervention noting the necessity for both in the achievement of optimum outcome for the patient.

Little research is currently underway into the physiotherapist/patient relationship. Three key studies exploring this relationship have been published by Scandinavian authors, Stenmar and Nordholm (1994), Gard et al (2000) and Talvitie and Reunanen (2002). The first two groups report on the psychological aspects of the physiotherapy/patient relationship and are critiqued below in 2.2.3.3. Most recently, Talvitie and Reunanen explored the patient/physiotherapist interaction through videotaping nine physiotherapy

sessions with patients with stroke (three men and six women aged 42 – 85 years, mean age 62 years) with the aim of discovering how physiotherapists construct their therapeutic encounters through conversation. Discourse analysis was used to analyse the data. The treating physiotherapist identified the patients and chose the single intervention to be recorded. Another participating physiotherapist made the video. No researcher was present. Talvitie and Reunanen found that physiotherapists led the course of treatment and, rather than discuss potential goals, were more likely to give information about the impairment effects of stroke, often using medical jargon. The researchers conclude that little initiative was taken by the patients and where it was, the physiotherapists "had difficulty in giving them space". Talvitie and Reunanen felt that patients' real concerns were not being addressed and concluded that their study gave cause to "question the unequal role distribution and authoritarian use of power in physiotherapy". Their observations were not followed up by interviews with the participants and it is not known whether the patients and physiotherapists concurred with these conclusions or whether the patients had any aspirations to a more equal role in the encounter. In addition, it is not possible to judge whether the recorded and analysed treatment sessions were representative of the entire episode of care, nor the potential for different responses due to the participants knowing the session was being recorded. Discourse analysis as used in this research is sited within the Foucauldian tradition (Holloway, 1997: 49) and is primarily concerned with the power/knowledge relationships that occur within social locations or institutions (Gubrium and Holstein, 2000: 494). Whilst this makes it an appropriate methodology for exploring the clinician/patient relationship it has the capacity to disregard other potentially important themes and concepts arising from the data thus missing other important factors. For example, in this study a recurring theme from the transcript sections included in the paper is the observation of patients' responses to different types of professional and human touch from the physiotherapists and yet this is ignored in favour of the perceived power relationship apparent in the discourse.

In respect of inter-personal communication skills and inherent professional hierarchy the therapeutic relationship between physiotherapist and patient seems to be very similar to

other healthcare professions. The key differences arising in the literature are that of touch and the amount of time spent with the patient.

Although other health care professionals touch the patient to assess or even perform very intimate examinations or treatments, the touch involved in physiotherapy is perceived differently. Mason (1985) sees touch as part of the physiotherapist's holistic approach that in itself is "a major contribution to care". He proposes that touch is an important part of healing suggesting that this is because, throughout human development, touch is linked with feelings of safety and security. However, Mason cautions that the manner of touching is important so that it is perceived as therapeutic rather than clumsy, inappropriate or unprofessional. Williams (1986) states that physiotherapists' handling skills are their greatest asset noting that "this laying on of hands approach can create a bond between patient and physiotherapist, building a relationship of confidence and trust which can in itself be therapeutic and vital for motivation". Martlew (1996) explored the impact of physiotherapy on patients attending a day palliative care facility and found that touch was a powerful tool that could positively affect patients who previously felt isolated, useless and anxious. McCorkle (1974) considered the effect of touch on seriously ill patients from a nursing perspective and concluded that physical contact may, of itself, be therapeutic. Hough (1987) concurs from a physiotherapeutic perspective and suggests that this may be the reason why many physiotherapy interventions appear to benefit patients despite a paucity of scientific validation. However Hough too cautions that touch must be appropriate so that patients appreciate that physiotherapists are working with them, not on them.

Pratt (1978) describes touch as one of three components of the physiotherapeutic relationship, the other two being the time spent in face-to-face contact and the practical benefits of the treatment. Klaber Moffat and Richardson (1997) note the opportunities the physiotherapist has to spend a longer time with the patient during the consultation-treatment, in the number of encounters during an episode of care and in consistency. They state "the development of an effective therapeutic relationship can also be facilitated by seeing the same person several times over the course of a few weeks".

Hailstone (1969) and Alexander (1973) note that physiotherapists spend longer in a one to one relationship with a patient than any other single member of staff. However, Hailstone cautions that such close contact could compromise the physiotherapist requiring a degree of professional detachment to maintain the therapeutic relationship. Both Hailstone and Alexandra describe practices that were occurring some thirty plus years ago. It will be interesting to explore whether physiotherapists and older patients feel that this level of contact still occurs at the start of the twenty first century.

Patients can perceive the time spent with the physiotherapist as valuable. In a study of disabled people's perceptions of physiotherapists (Johnson 1993) one person describes their experience of physiotherapy as positive because he worked with the same physiotherapist every day for ten weeks. He felt that the physiotherapist took an interest in him and engaged him in treatment planning. Another person reports her physiotherapist as being "wonderfully supportive", having time to talk, unlike other staff. Not all disabled people have the same positive experience. Interestingly, where dissatisfaction is noted it is almost exclusively to do with the physiotherapists' interpersonal skills rather than their technical expertise. Johnson concludes that relationships founded on detachment, lack of interest or pity give rise to resentment, indignity and demoralisation. Farthing (1973) is a physiotherapist writing from a patient perspective following surgery. She also notes the physiotherapist as being "the one constant factor in a rota of duty changes" and sees the physiotherapist's relationship as crucial in reducing the patient's ignorance, fear and uncertainty. However, as a physiotherapist she cannot speak purely from a patient perspective, as she would already have some knowledge of her condition, treatment and prognosis.

It would appear that physiotherapists have an important duty to optimise their role in the physiotherapist–patient relationship in order to develop a rapport with the patient to optimise the impact of the therapeutic intervention and patient satisfaction.

2.2.2 Therapeutic Relationships: A Rationale

The Oxford Dictionary (1992) defines a relationship as "a connection or association e.g. a working relationship". Therapeutic is defined as "of healing: serving to improve or maintain health".

From the above discussions it can be seen that health care professionals consider that the therapeutic relationship differs from other relationships including personal relationships with partners and family, relationships with work colleagues and friends, meetings with acquaintances or casual encounters with service providers such as shop assistants.

Donabedian (1979) was one of the first proponents of evaluation of the quality of medical care. He stated there are two components of quality healthcare, technical competence and interpersonal factors. These two components are seen as a thread running through the definitions of therapeutic relationship in all the health care professions discussed above. However, the need for good technical and interpersonal skills are crucial, not only to relationships in healthcare but also to other consumer-provider encounters, for example a driver taking their car to be serviced at the local garage. The way in which the therapeutic relationship differs must be in its rationale; that is, it exists to facilitate healing. One participant in the relationship is the "healer" and the other, the person seeking "healing". Classically it is described as a two-way partnership between an individual healthcare professional and the patient. It exists to facilitate delivery of and engagement with the clinical intervention that aims to optimise physical and/or mental health. In the case of physiotherapy this is usually linked to mobility and functional ability.

It can be seen from the previous discussions that the therapeutic relationship has distinct characteristics common to all health professions. The first is that the therapeutic relationship is deemed to exist and fulfil an important role in the healing process, being the vehicle through which intervention is delivered. Secondly, although it can be present from the first patient-healthcare professional encounter it also evolves over time. It is seen ultimately as a partnership, where the patient has both responsibilities and rights but

where the professional undoubtedly holds the power. The extent and depth of the relationship varies according to the personal characteristics of the participants and the extent and relative importance to the patient of the condition for which s/he seeks healing. The therapeutic relationship is not seen as occurring automatically and the ability to initiate and maintain this is not felt to be inherent in all health care professionals, although the skills that comprise the relationship can be learned. It is also a fragile entity easily harmed by either participant. This fragility may make it difficult for the parties to strike the right balance. The importance and fragility of the relationship makes it open to abuse from either side. Where the relationship exists there is a natural history of process, having a beginning, middle and end, the end being dictated, usually, by the end of the episode of care.

Although the literature extols the characteristics, components and importance of the therapeutic relationship it is by no means certain that every health care professional-patient encounter results in a relationship that involves both interpersonal skills and clinical expertise. The literature does not explore clinical encounters where a therapeutic relationship is said not to exist.

Historically the therapeutic relationship has been the main stay of the healing art, primarily because scientific knowledge was limited. Dixon and Sweeney (2000) consider that it is only in the last two hundred years that advances in medical knowledge have caused the medical profession to relinquish its humanistic roots and take a more reductionist stance culminating in the movement towards evidence based medicine. This, they say, effectively puts the entire onus for healing on technical competence whilst paying only lip service to the impact of the therapeutic relationship in mainstream medicine in the UK through the Government's call for improved patient partnership. Complementary therapists cite, amongst other things, this change in the personal clinician/patient relationship as a reason why more people are seeking complementary therapy (Oschman, 2000).

As physiotherapy becomes more researched and develops its own evidence base it is important to explore the existence, relevance and impact of the therapeutic relationship seen by many as vital to the "healing process".

2.2.3 Constituents of the Therapeutic Relationship

From the literature it is possible to identify five key constituents that make up the therapeutic relationship: inter-personal skills, professional factors, psychological dimensions, social dimensions and ethical issues. Although these are considered in turn there is considerable overlap. The literature exploring the specific role of the patient is also discussed.

2.2.3.1 Inter-personal Skills

All health care professions identify the role of communication in the clinician-patient relationship deeming it vital for ascertaining diagnosis and promoting adherence to treatment regimes (Hough, 1987). McQueen (2000) states that communication is fundamental to the formation of a trusting professional relationship in nursing with several commentators stating that clinician-patient communication is closely linked with patient satisfaction (Hall and Lloyd, 1990; Greene et al, 1994). McMillan (1995) feels that the importance of meaningful communication between clinician and patient cannot be overemphasised. To this end much has been written on how to develop and use these skills in practice to best advantage (Purtilo, 1990; Burnard, 1992; Lloyd and Bor, 1996; Myerscroft and Ford, 1996; Williams, 1997).

Klaber Moffat and Richardson (1997) divide these necessary communication skills into two categories: instrumental or task-orientated components and affective or socio-emotional behaviours (after Hall, Roter and Katz, 1987). They define the instrumental components as more overt communications including questioning, explaining/informing, instructing, use of language, demonstration and medical touch. Socio-emotional behaviours include less directive components such as empathy, reassurance, listening and quality of voice. They also include non-medical touch associated with reassurance rather than clinical intervention into this category. They assert that the use of both instrumental

and socio-emotional behaviours lead to a "warm and directive behaviour" that can help to bring about an improvement in the patient's signs and symptoms. Such socio-emotional behaviours could be seen as moving towards the communication skills required in counselling. Indeed, Hagedorn (1995) regards counselling, listening, empathy and unconditional positive regard as important communications skills required by occupational therapists to optimise the therapeutic relationship.

Daubenmire et al (1978) state that as well as exhibiting verbal and non-verbal communication skills themselves, nurses must be sensitive to verbal and non-verbal messages from patients. They suggest that because a patient is ill the nurse must take primary responsibility for communication as disease may affect the patient's ability to communicate (Hough, 1987).

The way that language is used is seen to be important in the clinician-patient relationship. Peloquin (1987) discusses the particular use of language to "command respect, admiration and hope" in psychiatric patients. Hagedorn (1995) notes the importance of a reassuring tone of voice, correct speed and content of delivery in communicating with all patients. However, Bourhis et al (1989) caution against the use of medical jargon noting links with poor patient understanding whilst Williams and Harrison (1999) identify this as a form of social closure excluding patients from the clinician's culture and reinforcing inappropriate power relationships.

Mason (1985) sees therapeutic touch as a powerful means of communication by physiotherapists. Other health care professions do not identify this as a major communication skill although the nursing profession does value non-therapeutic touch as an aid to demonstrating caring (Ramos, 1992; Ford, 1995).
Although communication skills are seen as vital for the therapeutic relationship, Hough (1987) cautions that good communication skills and technical competence are mutually exclusive and both are needed to achieve best clinical effect.

2.2.3.2 Professional Factors

Professional bodies are clearly influential in the practice boundaries of their members acting in educational and regulatory roles. Physiotherapy practice is informed and policed by professional standards (CSP, 2000). These relate to both clinical and service delivery aspects of physiotherapy intervention and are informed by the views of chartered physiotherapists and patients. The therapeutic relationship, although not referred to overtly, is inherent in these standards. The first core standard refers to respect for the patient as an individual in all aspects of the physiotherapeutic relationship and encompasses communication, information, courtesy and dignity. Core standard eight concerns patient partnership and core standard eleven refers specifically to the physiotherapist's responsibility to communicate unambiguously and openly with the patient, being skilled in active listening and providing patients with the opportunity to communicate effectively themselves.

The World Confederation of Physical Therapy (WCPT) defines physiotherapy as being "concerned with identifying and maximising movement potential including assessment, diagnosis, planning, intervention and evaluation" (WCPT, 2003). These professional skills are also governed by rules of professional conduct within which each chartered physiotherapist must practice. The Chartered Society of Physiotherapy's first rule of professional conduct (CSP, 2002b) states "chartered physiotherapists shall only practice to the extent that they have established, maintained and developed their ability to work safely and competently". In addition, the WCPT identifies the need for good interaction in order to deliver this practice, considering it to be part of the physiotherapists' professional skills. They state "interaction aims to achieve a mutual understanding between physical therapist and the patient/client/family or care giver and forms an integral part of physical therapy" (WCPT, 2003). Similarly, the CSP recommends the development of therapeutic relationships with patients based on "mutual trust and respect" (CSP, 2002b, Rule 2.8).

Clearly, the professional bodies consider the therapeutic relationship to be part of the professional role, if not a professional skill, of the physiotherapist. Despite this, no

definition of therapeutic relationship is offered, neither is there any guidance on how such a relationship should be established. The CSP, however, makes it very clear that inappropriate relationships will not be tolerated. These include those where the physiotherapist misuses their position in respect of sexual or power interactions.

These rules of professional conduct can create tension. Hough (1987) identifies the stress felt by some physiotherapists who feel they compromise their relationship with a patient due to differences between personal beliefs and professional practices. She cites physiotherapists feeling they could work better with patients and their relatives in some situations if communication between members of the multi-disciplinary team was more honest. Hagedorn (1995) speaking of occupational therapy feels that "carers need care" and it is the responsibility of professional colleagues and managers to provide this. In support of the individual occupational therapist she states that acknowledging a need for professional support and seeking supervision or support is an affirmation of coping skills rather than admission of failure. She notes that a failure in the support system can lead to professional burn out and that the professions have a responsibility to train therapists to ascertain their own strengths and limitations in relationships with patients. Even Williams and Harrison (1999), proponents of equality of patient and therapist power in the therapeutic relationship, note that professional distance is arguably necessary to protect health professionals against the strain of caring.

2.2.3.3 Psychological Dimensions

It is clear from the literature that many commentators see a strong psychological element to the therapeutic relationship. Hagedorn (1995: 105) and King (1989) consider that the individual therapist's values, attitudes and beliefs affect the therapeutic relationship. Stenmar and Nordholm (1994) state that physiotherapists' beliefs probably reflect how they view their professional practice. This is developed by Tyni-Lenné (1991) who describes how beliefs influence physiotherapists to take one of two approaches. One is impairment led and the other, which sees the patient-therapist relationship as key, is the basis for a learning process whereby the patient achieves health as the goal (Stenmar and Nordholm, 1994).

Stenmar and Nordholm (1994) consider the impact of physiotherapists' beliefs on the patient-therapist relationship within the context of attribution theory. This theory is based on phenomenal causality where people see their social environment as predictable and attributable to various events in their world. They suggest that physiotherapists make causal attributions as to why a treatment succeeds or fails. They consider that this causality is individual and informed by personal and professional beliefs and experiences. Whether physiotherapists make similar causal attributions to the success or failure of the therapeutic relationship is not discussed.

Another group of Swedish researchers explored the underlying emotions experienced and expressed by physiotherapists when treating patients (Gard et al, 2000). They consider that the therapeutic relationship is enhanced when physiotherapists respond on an emotional as well as an intellectual level. Affective behaviour, that is behaviour that reflects attitudes, values, beliefs, needs and emotional responses, is still seen as an under researched element in the response of physiotherapists in the physiotherapist-patient relationship. Gard et al consider it important for a physiotherapist to correctly interpret a patient's emotional responses and reflect those through empathy, including expressing emotions of their own. It is unclear whether this involved reflecting the patient's emotions back to them or sharing their own emotions within the encounter. As this paper reports a Swedish study and the writing is stilted in parts, this may be a translational error rather than inaccurate analysis or interpretation. However, if physiotherapists are indeed being encouraged to disclose their own emotions as well as their professional knowledge as "responding in an intellectual level is not enough to achieve good clinical outcomes" (p238), there is no discussion on the depths to which physiotherapists should share their own emotions, nor the boundaries that need to be established in order to remain within professional rules of conduct. Whilst this paper admittedly only explores the physiotherapists' perspective, conclusions are drawn about the potential for impact on the therapeutic relationship even although the patient view is not portrayed. The term 'relationship' assumes more than one participant and it is inappropriate to make assumptions based on the perspective of one party.

Attachment theory (Bowlby, 1973) highlighted the need for animals to form attachments to their mothers and others. This theory has since been used to explain the basis of human relationships (Bowlby, 1988; Gaines and Liu, 2000; Guerrero and Andersen, 2000). There is, however, no literature relating attachment theory to the physiotherapist/patient relationship.

Other models are related to occupational therapy and are more concerned with the personality of the therapist. Lloyd and Maas (1993) describe the helping relationship that they relate to Carhuff's model. Carhuff proposed that ineffective interpersonal skills could actually be detrimental to the therapeutic relationship and suggested a framework that describes the nature of the helping relationship. Carhuff states that "it is the manner of the helper, not his theory or technique that communicates understanding and fosters growth" and thus describes the core dimensions of the helping relationship as empathy, respect, genuineness and concreteness.

Other commentators consider the psychological components of the relationship from the patient's perspective especially where therapy intervention includes advice and education aimed at helping a patient to prevent recurrence or manage long-term disability. Klaber Moffat and Richardson (1997) believe that it is necessary to take a patient's attitudes and health beliefs into account when trying to influence their behaviour in the management of chronic pain. They link patient compliance with the Health Belief Model and the concept of Health Locus of Control and use these models in their management of patients with chronic pain. Bury (1997) associates health beliefs with people's beliefs about mortality but does not consider the impact of these on the clinician-patient relationship. Other than Klaber Moffat and Richardson, physiotherapists do not discuss the use of these models so it is not known whether they are particularly pertinent in the field of older person's rehabilitation.

2.2.3.4 Social Dimensions

Social factors play an important part in the literature describing therapeutic relationships. Nettleton (1995) identifies three key issues that she considers to have relevance to the

development of relationships in professional-patient encounters. Firstly she considers that lay-professional relationships both reflect and reinforce wider social relations and structural inequalities (p131). Related to this she sees such relationships as perpetuating existing social controls and also notes that health professionals are seen to limit health care through neglecting to take patients' views seriously. However, she concedes that the quality of the interaction impacts on the outcome, presumably for good or ill. Radley (1994) too considers the healing relationship from a sociological perspective noting that people lose their individuality and become patients when they consult a health care professional. This description is irrespective of the ailment with which the person presents. This could be seen as reinforcing the power relationship seen by many as inherent in the therapeutic encounter. However, Radley disputes that the relationship is always so one sided suggesting that some of the dynamics of the interaction come from the patient's approach, wanting to be treated and "made well". Radley suggests, "where the authority of the doctor is legitimate in the eyes of the patient, questions of a struggle for control do not arise". Williams and Harrison (1999) however, consider that power is an aspect of all human relationships from which the therapeutic relationship is by no means immune and question whether healthcare professionals and their clients are aware of the power variable during the therapeutic interaction. They describe Cahill's model (1996), which provides a concept analysis of patient participation. This model defines a hierarchy of patient involvement in the therapist-patient relationship moving from patient involvement to collaboration, participation and culminating in partnership. Williams and Harrison see this as representing "an ideal to which the therapeutic relationship aspires" reflecting a power shift in the therapeutic encounter. Williams and Harrison hypothesise a framework for the power dynamic in the physiotherapeutic relationship. This model comprises three inter-related factors; the therapist, the patient and the environment. This power dynamic is illustrated as constantly changing with different forces pulling in different directions throughout the course of the encounter.

Bernstein and Bernstein (1980) consider that "a major obstacle to harmony in the therapeutic relationship" is the inability of the clinician and the patient to relate to each other due to differences in educational, social and economic circumstances.

Traditionally, physiotherapy is a middle class profession and Williams and Harrison (1999) note that social discrimination may be perpetuated through physiotherapists' attitudes, lack of understanding and preconceived ideas attached to patients from lower status groups. Hall and Lloyd (1990) stress the importance of socialisation in the ability of health care professionals to communicate with each other and their patients which, they consider, is key to a satisfactory therapeutic relationship. Hagedorn (1995: 105) too, considers that values are cognitive constructs being culturally determined, learnt through primary socialisation in early life and secondary socialisation in professional training.

Disability theorists consider the concept of disability in people of all ages to be a form of social oppression rather than a personal tragedy as postulated by the charitable model or a case for medical management as perceived by the biomedical model (Bury, 1997; Williams et al, 1998). Finklestein (1988) argues that the medicalisation and social oppression of the person with disability perpetuates the image of the victim and suggests that treatment and care, including rehabilitation, is a form of medical and social imperialism. Nettleton (1995) sees any relationship forming under these circumstances as asymmetric and likely to be problematic.

Williams and Harrison (1999) describe the hospital setting as an "alien environment for patients, often associated with pain, fear and illness". Hough (1987) considers that the subculture of hospital life affects the therapeutic relationship. She notes that the patient is excluded from the clinician hierarchy through the use of medical language, active exclusion from medical discussion and feelings of inadequacy and embarrassment caused by their state of undress. Radley (1994) identifies the power and exclusivity of uniform in further alienating an equal relationship although he also notes that uniform may also reassure patients of the clinician's role and expertise.

Other factors seen to impact on the doctor-patient relationship by Radley (1994) include the gender and age of the doctor relative to the patient, the role of the doctor in legitimising the sick role and the belief that sickness may be seen by the patient as a deviant state in society. Radley sees the belief that the doctor has an inherent healing

power as a "therapeutic illusion" contributing to the placebo effect. However, Dixon and Sweeney (2000) would not consider this to be a social or psychological construct preferring to describe this phenomenon as the doctor tapping into the person's inherent ability for self healing.

2.2.3.5 Ethical Issues

Few elements of clinical care can be isolated from the growing concern with ethical issues. Ludwig (1998) writes that although the historical model for the physician-patient relationship involved patient dependence on the physician's authority, during the latter half of the twentieth century this relationship has evolved towards shared decision making. This new autonomy has led to increased anxiety amongst doctors who fear that "this increase in patient power will lead to a greater risk of litigation against their physicians" (McMillan 1995). McMillan advocates taking an approach of responsibility *to* the patient rather than responsibility *for* the patient as a means of avoiding the potential ethical problems relating to coercion and choice. He suggests that doctors need to devise a way of acting in their own interest whilst ensuring that "both physician and patient remain moral agents with unique contributions to make to the achievement of a shared goal".

Other ethical considerations identified in the therapeutic relationship literature include informed consent and the need for truthfulness. Williams and Harrison (1999) identify the role of the physiotherapist in ensuring informed consent to treatment. They state that health professionals are obliged to provide all information to ensure patient understanding and consider that fear of litigation is driving a heightened awareness of obtaining explicit consent to treatment. Sim (1986) takes up the theme of full and appropriate information for patients. He considers that "the patient who is fully informed can participate fully in a treatment regime" and that dishonesty on the part of the physiotherapist can destroy a relationship that needs to be built on mutual trust. However, Sim cautions that the need for truth must not detract from patient confidentiality.

2.2.4 The role of the patient

So far, the onus for developing and maintaining the therapeutic relationship has been attributed to the clinician. However, various commentators note that the patient has an active and important role to play in the partnership and that this role is determined by the patient themselves rather than as a reaction to the instigation of the healthcare professional. Williams and Harrison (1999) note that the patient is not powerless in the relationship having the new found power to challenge professional decisions and more equality in accessing the necessary information to make those decisions. Internal mechanisms such as level of co-operation are also the choice of the patient and this may cause the making or breaking of the relationship. Waterworth and Luker (1990) suggest that not all patients are enthusiastic collaborators in the therapeutic relationship and may display this through aggressive or demanding behaviour. Some patients may display overt violence towards healthcare professionals although the incidence of this in physiotherapeutic relationships is unknown. Van Rooijen (1993) suggests that such anger may be directed towards the system rather than the individual physiotherapist. However, whatever the underlying cause, the destructive impact on the relationship remains the same.

Other less aggressive behaviours can disadvantage the therapeutic relationship. Peloquin (1988) states that the attitude an individual brings to the situation can influence the therapeutic relationship. If a patient expects to receive little therapeutic gain this will reduce collaboration with the clinician. Ogden (1996: 68) cites Ley's cognitive hypothesis model of communication, emphasising responsibility of the patient in engagement with the communication process.

Morse (1991) identifies four types of mutual relationship that develop between nurses and their patients: clinical, therapeutic, connected and over-involved. Although she identifies both nurse and patient perspectives, the patients interviewed in her study were also nurses and as such could be expected to have views informed as much by their clinical as their patient status.

Similarly, when considering the role of truthfulness in the therapeutic relationship, Sim (1986) identifies the responsibility of the patient to share complete and true information with their physiotherapist to ensure a therapeutic relationship that can aid in the pursuance of a joint therapeutic goal.

2.2.4 Summary: Therapeutic Relationships

This review has identified that many commentators rate the therapeutic relationship as being equally important as the technical skills of the clinician. In very general terms nurses consider this relationship to be one of caring, doctors as one of trust, occupational therapists as one of helping and physiotherapists as an interaction to promote compliance for therapeutic gain. Regardless of terminology, all health care professions regard this relationship as a vehicle for healing and in this respect the therapeutic relationship differs from all other relationships. The magical and mystical power of the relationship has, for millennia, been considered as having the capacity for healing in its own right (Read, 1925; Hagedorn, 1995; Dixon and Sweeney, 2000). However, recent literature suggests that the key components of the therapeutic relationship are more likely to be found in communication skills, psychological and social dimensions, professional and ethical issues and in the response of the patient.

Whilst the quality of individual papers varies, overall the literature surrounding the therapeutic relationship is extensive and robust, having improved generally over the past ten years. Peer reviewing of papers submitted to physiotherapy journals particularly has improved the quality of published work and this is reflected in the standard of the more recent papers exploring aspects of the physiotherapeutic relationship. However, this has also highlighted the gaps in knowledge in this area, particularly around the social dimensions where only two authors (Williams and Harrison, 1999; Harrison and Williams, 2000) have considered this perspective.

This, together with the literature identifying the five key constituents as perceived by health care professionals and the role of the patient in the therapeutic relationship helped to ascertain the extent of current knowledge in this field and to clarify and refine the

research question "What is the essence of the physiotherapeutic relationship in older persons' rehabilitation? Specifically, what are the experiences and perceptions of physiotherapy clinicians and their older patients of the constituents, role, value and impact of the therapeutic relationship that develops during medium to long term rehabilitation?" These reviews also informed the initial interview guides for the first two studies. The method by which this question was addressed is discussed in the next chapter.

Chapter Three

Exploring the Therapeutic Relationship: methodological considerations

3. Introduction

This thesis is an exploration of the therapeutic relationship that develops between physiotherapy clinicians and their older patients undergoing medium to long-term rehabilitation in outpatient and domiciliary settings. A pilot study was undertaken to ascertain the relevance of the topic and appropriateness of the proposed data collection and analysis method. Two further studies explored the perceptions and experiences of physiotherapy clinicians working in older persons' rehabilitation and older patients who had recently completed a course of physiotherapy. Individual, in-depth interviews were employed. A final study explored individual relationships between older patients and their physiotherapy clinicians. Individual treatment sessions were observed and these were followed up with individual interviews with each physiotherapy and patient participant.

This chapter outlines the philosophical basis on which this research rests. It explores the rise of qualitative research within physiotherapy and the use of grounded theory methodology for exploring perspectives and experiences and developing theory from interview data. The theory and practice of sampling is discussed in relation to this research. The importance of establishing truthfulness and methodological rigor through sampling, data gathering and analysis is identified together with a short reflection on the impact of the researcher on the process and the process on the researcher. It also includes a report of the pilot study that preceded the main studies.

3.1 Philosophical Basis

This research sought to explore the factors that inform and influence the existence, components and development of the therapeutic relationship between physiotherapy clinicians and their older patients. There are many ways in which this question could be addressed but it was decided to explore it within a sociological paradigm that concentrated on the 'accounts' of both parties. This decision was based on discussions

with clinicians and academics and a personal interest in appreciating differing perspectives of different people in similar situations. Other options considered included taking a more psychological perspective and exploring 'beliefs' and 'attitudes' from a positivistic position. Prior, Lai Chun and Beng Huat (2000) consider the sociological angle to be "publicly available and verifiable". This, together with personal preference and after discussion with supervisors, led this inquiry to take a qualitative approach within a social constructionist paradigm.

The social constructionist paradigm is a set of beliefs characterised by a move away from positivist and post positivist traditions, from ontological realism to ontological relativism (Schwandt, 2000: 197). This relativist ontological perspective considers there to be "multiple, apprehendable and sometimes conflicting social realities that are the products of human intellects" (Guba and Lincoln, 1998: 208). These realities and the constructs they inform are not fixed, being perceived differently by different individuals and subject to change as the individual becomes more informed through new experiences. This inquiry approach, whilst aiming for consensus, is open to new interpretations and develops continually as the social, cultural, political and economic world changes. Epistemologically, the investigator cannot be divorced from this world and is an active participant in the inquiry process, defining realities and constructs that are informed and influenced by their own experience and understanding. Methodologically this approach is hermeneutic and dialectic as the constructions can only be elicited and refined through interaction between and among investigator and respondents.

The social constructionist paradigm states that knowledge is not discovered, rather it is constructed. Individuals then devise models to make sense of the experience and these are continually tested and adapted in the light of new experiences (Schwandt, 2000: 197). A social constructionist approach to the exploration of the therapeutic relationship facilitates the exploration of the differing perspectives of the participants and allows for the inclusion of the potentially different interpretive perspective of the researcher. It also allows models or theories to be developed and tested.

Grounded Theory Approach sits methodologically within this paradigm being inductive, with theory created from the original raw data through constant comparison and theoretical sampling, recognising that 'the viewer creates the data and ensuing analysis through interaction with the viewed' (Charmaz, 2000: 523). This approach, chosen to explore the therapeutic relationship from the perspectives of physiotherapy clinicians and their older patients, is discussed below. Grounded theory methodology has been widely used in medical sociology, however its use in exploring the impact and role of physiotherapy and its value in creating theory in this field is only just starting to emerge.

Other qualitative methodological approaches to exploring the physiotherapeutic relationship were also considered. The thick, rich description arising from a phenomenological approach was appealing but was rejected in favour of using an approach that had the ability to devise a clinically applicable theory. Discourse analysis, which explores how language shapes and is shaped by the cultural and social context in which it occurs was also rejected because of its concentration on this and its potential to discount other important themes and concepts. An ethnographic approach having its roots in phenomenology and anthropology had the capacity to explore the "symbolic world" of the physiotherapeutic relationship within its natural setting (Bowling, 1997:316) through observations and interviews. This was seriously considered initially but later shelved as it became apparent that the physiotherapeutic relationship required further "unpicking" in order to ascertain what elements needed to be observed. Practically too, substantial service changes prevented the longitudinal study required for true ethnographic inquiry.

3.2 Using Qualitative Approaches in Physiotherapy Research

Physiotherapy research by physiotherapists is still in its infancy particularly in relation to qualitative, constructivist approaches. Arising from a predominantly scientific/biomedical model (Pratt, 1989) the majority of physiotherapy research to date has been empirical, mimicking medical research, particularly through experimental and clinical studies. In 1990, Parry identified the need for the physiotherapy profession to evaluate its modus operandi through rigorous research. She was adamant that this

research should reflect what she saw as the distinct paradigms of physiotherapy practice ranging from the biomedical approach of 'spinal manipulators' to the holistic approach of 'physiotherapists caring for elderly people'. She stated that the evaluation of these models required different methodological approaches and warned against physiotherapy research falling into the trap of "rejecting qualitative methods of inquiry disparagingly...as 'soft'" (Parry, 1990).

To explore whether these concerns have been addressed, a hand search was undertaken of two separate years of the journal 'Physiotherapy', the professional journal of the Chartered Society of Physiotherapy, published a decade apart. The journals published in 1990 (chosen as this was the year of Parry's call to more rigorous professional evaluation) revealed a total of thirty-four research papers, twenty-nine of which were quantitative, being experimental or clinical studies or questionnaire surveys. Three were reviews of the literature leaving only two that could be described as qualitative. These were patient observations but both lacked the rigor of true observational research described by Mason (1996: 60-72).

A decade later, it would appear that Parry's advice had been heeded. This is noted in a similar trawl of 'Physiotherapy' in the year 2000. The research published during this year represents a significant change in the approach of physiotherapists to the evaluation of their interventions. Thirty-five research papers were identified. Twenty were quantitative (experimental, clinical, questionnaire survey, Delphi and case studies), four were literature reviews and another three, more rigorous systematic reviews. Eight papers reported qualitative research, of which three employed interviews with people receiving physiotherapy. These were undertaken using a grounded theory approach (Nicholls, 2000; Cook and Hassenkamp, 2000; Bäckström and Dahlgren, 2000).

Other factors have also influenced the rise of more academic and rigorous research in UK physiotherapy. Within the last ten years physiotherapy has become an all degree profession, training physiotherapists in research and critical appraisal skills at undergraduate level. In addition, research articles submitted to 'Physiotherapy' are now

peer reviewed. The push towards evidence-based practice in the 1990s also fuelled the move towards a new respect amongst physiotherapists for research, its dissemination, appraisal and application to clinical practice. A new career pathway of research physiotherapist is starting to open up in individual Trusts in the NHS.

The precedent for the use of the grounded theory approach in physiotherapy research remains weak. It is clearly unusual for physiotherapists to have a research background in this method and although each of the three grounded theory papers in the 2000 Physiotherapy Journals has a physiotherapist as first author, they are written in collaboration with medical sociologists who have this specialist expertise. A wider, international search of Cinhal 1982-December 2001 and Embase 1993-December 2000 undertaken in January 2001 using the key words grounded theory and physiotherap* in all fields, identified 72 different papers. Of these, 13 reported physiotherapy research utilising individual interviews with grounded theory approach. Four of these were undertaken in the UK, five in the USA and Canada, two in Australia and two in Sweden. Of these13, only two reported completing the grounded theory approach cycle through the development and testing of theory (Teram et al, 1999; Nicholls, 2000). None have explored perceptions of physiotherapists working in older person's medicine or older people receiving physiotherapy. There are, however, grounded theory studies exploring similar fields such as stroke and occupational therapy (Pound et al, 1998a; Stephenson and Wiles, 2000).

Since that literature review was undertaken there has been a steady increase in the use of qualitative research in physiotherapy suggesting that, along with its increased use in the medical literature, it is gaining ground as a credible and important approach. This is highlighted in a paper by Gibson and Martin (2003) who also feel that qualitative research is underrepresented in physiotherapy and argue that it has an important role in establishing the evidence base of the profession.

3.3 Pilot Study

The feasibility of exploring the therapeutic relationship between physiotherapy clinicians and older patients using grounded theory methodology was explored in a pilot study. The aims were as follows:

1. To:
    a. ascertain the relevance of therapeutic relationships to older people and the physiotherapists that treat them.
    b. see if physiotherapists, physiotherapy assistants and older people are able to identify the components and the process of the development of a therapeutic relationship between physiotherapists and older patients in day hospital, community and domiciliary settings.
    c. inform appropriate topic areas to explore further in the subsequent studies.
2. To explore the feasibility and value of grounded theory methodology in a study of this type.
3. To sensitise the researcher to the practical and academic issues of accessing experiential and abstract information from physiotherapy clinicians and their older patients.

These aims were addressed through the following:

1. Three focus groups with physiotherapy clinicians working with older people. This was an opportunity sample from a local NHS Trust and comprised a total of eight physiotherapy assistants and ten physiotherapists (two males and sixteen females) having a broad range of grades and experience with older patients. Participants were allocated to each group by grade to promote the freedom of sharing views in peer groups in accordance with focus group methodology (Millward, 1995: 279). Each group lasted between 30-50 minutes and was facilitated by the researcher. Each focus group was tape-recorded, transcribed and the data analysed using a content and thematic analysis (Smith 1995).
2. One group and four individual interviews conducted with older people all of whom had past health care experiences. Participants were an opportunity sample of one man and eight women aged 70 – 104 years. The group interview was held with five of the

older women in a Social Services Day Centre in Woking. The four individual interviews were conducted with the friends or relatives of friends of the researcher. Each interview lasted between 40-70 minutes. All interviews were tape recorded and transcribed. Field notes were written immediately after each group. The data were analysed using a content and thematic approach (Smith, 1995).

3. A reflection on the process to assess whether the research topic was considered to be of importance and relevance to both parties, to ascertain the most appropriate data collection and analysis methods to address this topic and to use this experience to inform the content of interview guides and good practical and academic approaches for the subsequent studies.

The pilot study findings showed that all the physiotherapy clinicians regardless of grade, experience and field of work with older people were certain that a therapeutic relationship did exist between them and their older patients, that this is a two-way relationship and was actively encouraged by the clinicians to facilitate the engagement of the patient with treatment. Other topics that emerged that were considered important to explore in the subsequent studies were:

- The links between the relationship and the course of treatment
- Disclosure of professional and personal self
- The role of communication skills, genuineness, trust and mutual respect
- The existence of good and bad relationships
- The role of gender in the relationship
- The role of touch in the relationship
- Other relationships that occur within the episode of care (e.g. with the multi-disciplinary team, with relatives)
- The links between the relationship and outcome.

Some methodological issues arose from the pilot study with physiotherapy clinicians. These were:

- The need to integrate the needs of the research with service delivery. This identified the need for sensitivity when booking interview times and being aware that if interviews over run this impacts on patient treatment time.
- The power of the senior clinical staff (including physiotherapists, service managers and consultants) in allowing access to staff for interviews. Negotiation and maintaining high levels of communication with these staff is vital if the required sample is to be accessed.
- It is easier, from a service perspective, to conduct individual interviews rather than focus groups.

Findings from the interviews with older people identified topics to address in the subsequent studies and some methodological issues. The older people were not so sure that a relationship, as they defined it, existed. Although they felt it was important to "get on with" their doctor or health care professional, the concept of "a relationship" was not a common experience. The term "relationship" was one they associated with friends and relations, not with healthcare professionals. The term "relationship" in its widest sense is used here to encompass the term "get on with" identified by the older people.

Key themes arising from the interview data considered important to follow up were:

- The impact of past health care experiences on the patient's role in any relationship with a healthcare professional
- The existence of good and bad relationships
- The role of patient and clinician knowledge and communication skills, faith in the clinician and the personal attributes of the clinician in the relationship
- The importance of listening and empathy from the clinician and the need for this to be shown in their actions
- The apparent links between "getting on with your therapist" and "getting better"
- The importance of the service as well as the relationship and the treatment
- The perception that the clinician is "the boss".

Methodological issues arising from the pilot study were:

- The difficulty of keeping some participants focused on the topic. For example, the impact of more recent health care experiences unrelated to physiotherapy may divert the conversation. To reduce this, interviews should be conducted soon after the end of the episode of care and attention should be paid to keeping interviews focussed whilst still allowing participants the freedom to explore their perceptions and experiences.
- It is probably not necessary to "warm people up" by asking about their past health experiences. Asking about early experiences of relationships with family doctors before the war as a means of exploring pre-NHS health care experiences not only detracts from the central research question but also appears to trigger war rather than healthcare memories.
- People tended to recall health care experiences along a "time line" of other memories that may hold more importance or relevance to them. It may be pertinent to explore these other life experiences to stimulate healthcare memories.
- Older participants jump between past and recent memories. It may be necessary to seek clarification from participants.
- Older people who have received a medium to long term course of physiotherapy for multiple functional problems are more likely to feel they have engaged with their physiotherapist than those who have received outpatient treatment for a single curable impairment.
- Initial denial of past illness and healthcare may change as memories return and experiences are recalled. There is a need to be patient to facilitate information sharing within the interview.
- Some people are repetitive and may perseverate on one particular memory or phrase.
- Some people automatically lay the blame for perceived poor relationships with healthcare professionals or poor health outcome on themselves. There is a need to explore behind the excuses made for these clinicians to identify the real issues. Tact, diplomacy and sensitive interviewing skills will be required.

The pilot study therefore addressed its aims of ascertaining the relevance of the central research question and in identifying that physiotherapy clinicians and older patients were able to articulate their views and experiences around this topic. On reflection, individual interviews were deemed the most appropriate way of ascertaining the views and experiences of these participants. It was viable to tape record interviews. This research was felt to be suitable for a grounded theory approach with data coming from the perspectives of the two main stakeholders and comprising individuals' perceptions and experiences. Theoretical sampling was a viable option, individual participants were relatively easy to access and recruit and the central research question lent itself to theory development.

The initial proposal of conducting a single longitudinal study following a number of patients and their physiotherapy clinicians throughout an episode of care was deemed impractical due to the service changes caused by NHS restructuring at the time of the research. Similarly, practical constraints would mean only a small sample of cases for study. This would limit the methodological requirements for data saturation in a grounded theory approach.

Dividing the study into three discrete studies: a) interviewing physiotherapy clinicians working with older people, b) interviewing older people just completing a course of physiotherapy within a rehabilitation rather than an outpatient setting and c) a shorter longitudinal study following a small number of patients and their physiotherapists through their episode of care, was considered to be the best methodological and practical way of addressing the central research question. The longitudinal study was later amended to the observation of four treatment sessions followed by in-depth interviews with the physiotherapy and patient participants due to time and service constraints. It also enabled further exploration of the experience and saturation of that data rather than moving the research on to investigate relationship development. The topics raised in the pilot studies were included into initial interview guides to form a starting point for the further exploration that is described in the subsequent chapters.

Following the pilot study, the academic and practical application of interviewing, grounded theory methodology and rigor were considered preparatory to undertaking the main studies.

3.4 Interview Methodology

Interviews have long been used to explore participants' perceptions and accounts of their experiences. They are an accepted way of ascertaining "detailed, richly textured, person centred information" in older persons' health research (Kaufman, 1994: 123). Mason (1996) describes interviews as a way of generating rather than collecting data. Semi and unstructured interviews particularly are driven by participant responses whilst being guided by interviewer leads. This approach reflects the underpinning ontological and epistemological approaches of this study as the views of participants in the relationship are deemed to be vital in understanding the therapeutic relationship. Interviewing is seen as a legitimate way of generating this data. Silverman (2000) describes interviews as a means of "accessing various stories or narratives through which people describe their world" rather than a means by which the "truth" of a situation may be discovered. Indeed, Mason (1996) warns that interviewing people about their experiences will necessarily be limited by their remembrances and interpretation that may differ from their understandings at the time of the incident they relate. However, the relativist approach takes account of the differing realities perceived at different times by the same people and this approach requires only the interpretation of the participant who actually experienced the event. Although observation by the inquirer at the time of the incident being explored may be seen to be a more "truthful" account, this brings another individual into the equation, interpreting the "truth" from his or her own perspective. It was decided that as the older patients and physiotherapy clinicians had been the main actors in the therapeutic relationship, their perceptions, whether immediate or considered, were entirely valid whereas the interpretation of an observing inquirer would add yet another perspective.

Wengraf (2001) states the importance of being well prepared for undertaking semi-structured interviews. This involves starting with the central research question that is divided into key theory questions that in turn are split into informant questions. The

informant questions are the only ones that are actually articulated but which together address the key and central research and theory questions. Strauss and Corbin (1998a) however, advocate a more flexible approach that, whilst having key topics that need to be explored in initial interviews, allows the freedom to divert from the original interview guide to explore the concepts that arise. This technique of varying the emphasis from one interview to the next is considered vital in grounded theory methodology in order to explore developing concepts and emerging theory. Wengraf (2001) does, however, suggest the use of a conceptual framework where the inquirer continually reflects on their questions and responses in the light of their own perceptions and biases. Because these are to a great degree, inevitable, he warns against taking participant responses out of context during analysis preferring to consider each response in the overall spirit of the interview rather than considering each comment in isolation.

Individual semi-structured interviews were used in this research to explore the views of physiotherapy clinicians and their older patients. Kaufman (1994: 125-6) feels that interviewing older people is no different from interviewing younger people. For all participants she advocates taking sociodemographic and functional characteristics into account. These include considering how much formal education the informants have, their cultural background and any cognitive impairment. These may be of greater import when there is a significant age gap between interviewer and interviewee. Kaufman states that any visual or hearing impairment must be taken into account when speaking and responding to participants, but warns against the interviewer coming to the session with preconceived stereotypes about older people leading them to talk unnecessarily loudly and slowly. This approach can influence the data collection process as the older person may feel they are not respected and respond accordingly. In addition the preconceptions of the interviewer will influence their analysis and interpretation of the information gathered. In this research these potentially negative influences were addressed through experience of working with older people, reflecting on the best way to approach interviewees and explore their views, and identifying potential stereotypes held by physiotherapists towards their older patients in an earlier piece of research (Barnard 2001) in order to avoid them.

Initial interview guides were developed from the central research question and theory questions using an approach modified from Wengraf (2001). Topics were identified to use as prompts to explore these issues. Some informant questions reflecting the topics were drawn up to use as starter questions to promote initial responses and where exchange flagged. The interview guides were continually revised according to earlier interview responses and analysis in order to explore the categories and concepts as they arose (see Chapter 4 and interview development appendices 4.1 and 4.2).

3.5 Observation

In the final study, inquirer observation was added to include another perspective on the relationship and further develop the theory.

During the initial groundwork for this research and an earlier study exploring the attitudes of newly qualified physiotherapists towards older people (Barnard 2001) visits were undertaken to several physiotherapy departments in Day Hospitals. Whilst waiting in these departments, casual observation of physiotherapy clinician and older patient treatment sessions appeared to show differences between the expressed views of the physiotherapy clinicians and the interpretation of events by the researcher. It is well recognised that observation adds yet another perception, that of the observer, to the interpretation of events (Bowling 1997: 321) and this will inevitably add a bias, particularly when the observer has knowledge and experience of the event under scrutiny. However, this research based only on interview data could be seen to be biased by virtue of both parties wanting to express only positive views: physiotherapy clinicians because they were talking to a fellow physiotherapy colleague and older patients because they were loath to complain when they may have to access physiotherapy services again in the future. Bowling (1997) sees the addition of observation as a means of taking a "triangulated approach to research" (p316). Keen and Packwood (1995) writing about the use of case studies in health service research consider that triangulation is an essential part of case study design where data is corroborated from more than one source preferable by another data collection method. Triangulation is, however, a method more commonly associated with quantitative research and Sim and Sharp (1998) warn against

assuming that triangulating data automatically validates findings stating that whilst it may assure the scope of the findings it is no guarantee of their accuracy. Glaser and Strauss (1967) see all data as valid and contributing to the inductive process of analysis in grounded theory methodology. It was decided to use the extra element of observation in the final study to form the basis of further questioning, allowing participants the opportunity to enlarge on their actions and reactions in the treatment session and also to enrich and clarify the information arising from the semi-structured interviews of the earlier two studies.

From an ontological perspective it is important to explore therapeutic relationships within their rehabilitation context to enable conceptualisation of these interactions where they occur. The epistemological position suggests that knowledge can be generated from observing real life settings as they occur and that the researcher can be an interpreter as well as an observer.

The data gathered through interviews from physiotherapy clinicians and older patients provides the perspectives of both parties and enables a model to be devised using a grounded theory approach. Observation of actual physiotherapy clinician/older patient encounters enables a new perspective to be gained including the process of the interaction, the way in which both parties act and react, putting previously described experiences into context and allowing the emerging theory to be tested and amended. Interviewing participants after the encounter gives both parties the opportunity to explain what happened from their perspectives and explain why they acted and reacted as they did. Participants' responses will also challenge the researcher's own interpretation of the interaction.

A "participant as observer" approach is used in this research where the researcher is in a purely observational role. However, the observation is overt (Mays and Pope, 1995), both physiotherapy clinician and older patient having given informed consent in an earlier meeting with the researcher. During these meetings time was spent with each person individually to negotiate access, explain the research, reduce possible anxieties

and make them feel comfortable. Prior to the actual observation the observer greeted both parties and then sat to the side taking no further part in the interaction other than to thank the participants at the end of the treatment session and arrange times for the follow up interviews.

The semi-structured observational approach taken in this study involved the use of an open grid for making field notes during the encounter (Appendix 6.1). The research question and findings from the first two studies informed the loose structure of the grid and the key features to be noted (Bowling 1997). The grid is divided into four discrete sections to aid data gathering. These are setting and participants, pre-treatment and introductions, treatment session and closure. Specific observations are noted regarding the actions and reactions of the participants. These included evidence of different levels of sharing information (professional, personal, "chitchat"); the response of the other party to this; initiation / engagement / rejection of attempts to form or develop a relationship; humour; touch and response to touch in relation to formation/development of the relationship; inclusion or exclusion of either party and others; imparting of and response to bad/good news; impact of relationship on clinical effects. As far as possible these events were recorded literally, however, the impact on the observer is recognised as important in the inductive analysis and conceptualisation within the grounded theory approach and the field note grid leaves space for interpretive notes to be written at the time or immediately afterwards. Reflexive notes were also written after full consideration of the data gathered from each of the case studies (Mason, 1996: 69). Interpretive notes arose from the researcher's interpretation of events. Reflexive notes took into account the researcher's past experience working in the field and their own response to the literal event noted. Field notes were transcribed, entered into the qsr Nud*ist software together with the follow up interviews and analysed using the constant comparative approach of grounded theory methodology. The field notes informed the follow up interviews with each participant. An example of this field note data appears at appendix 3.1.

3.6 The Use of Grounded Theory Methodology in this Research

Grounded theory methodology (GTM) was "discovered" by sociologists Glaser and Strauss (1967). GTM is characterised by an inductive approach, constructing theory from data through the development of concepts and categories using the method of constant comparison. Theoretical sampling is considered de rigueur in order to saturate data and is discussed in relation to this research in 3.7.1.

Data can be obtained from interviews, focus groups, documentation and observation. In the main studies of this research, data was obtained from individual interviews and, in addition in the final longitudinal study, observation. Grounded theory methodology follows a prescribed approach of coding and conceptualising (Strauss and Corbin, 1998a). The following method was applied to the data gathered in this research:

- Data collection
- Transcription of data
- Development of categories
- Saturation of categories
- Definition of properties and dimensions of the saturated categories
- Theoretical sampling
- Axial coding
- Theoretical integration
- Grounding the theory
- Filling in gaps

(Bartlett and Payne, 1997)

In the main studies data was collected through individual semi-structured interviews. The interviews were transcribed along with the field notes written after each interview. QSR NU*DIST 5 software was used to codify and organise the data. The data was subjected to open coding with initial themes and topics identified (free nodes) through line-by-line scrutiny of the transcripts. These were then assembled into categories (tree nodes). Category saturation occurred when further analysis ceased to discover anything new from the data. Once saturated, the properties and dimensions of the categories were described allowing an abstract definition of each category to be formulated. Although

Strauss and Corbin (1998a) concede that there is always some new interpretation that can be elicited from data, they state that a time comes when it is no longer theoretically or practically reasonable to continue with the lateral thinking process. The information gained from coding, categorising and saturation inform the exploration of further data from subsequent interviews (theoretical sampling). Strauss and Corbin (1998a) stress the importance of actively including negative or deviant cases. These data allow for the full range of properties and dimensions of the categories to be identified

Axial coding was then used to explore and redevelop these categories, creating concepts. Axial coding involves noting possible relationships between categories by relating their properties and dimensions. Strauss and Corbin (1998a: 129) warn against being too dogmatic and prescriptive in what is, essentially, a dynamic and creative process. It would appear that, although GTM follows a prescribed formula, there is an art to the conceptualisation of the data that requires a more lateral thinking approach.

Once concepts have been identified through axial coding they are defined through a brief description encapsulating their conceptual essence. Theoretical integration is the means by which these concepts are related to similar concepts within the literature in order to develop theory.

An example of how raw data obtained from this study was analysed using the grounded theory approach appears at appendix 3.2.

Grounding the theory in the data is an essential part of GTM as it ensures the truthfulness of the process and provides assurance that the theory arising is indeed a viable interpretation of the research. This theory is then tested through further data collection or by revisiting earlier data. Data from negative cases are used to develop and refine the parameters of the theory. An audit trail of the data collection, analysis and researcher thought processes is another tool used to show methodological rigor and the truthfulness of the findings. An outline example of the audit trail for physiotherapy clinicians' perception study appears at appendix 3.3.

3.7 Data Analysis

In this research the transcribed interviews and observations were entered into qsr NUD*IST 5 software for analysis. Field notes were also transcribed and entered into qsr NUD*IST 5. Preliminary coding was undertaken between interviews to enable the inclusion of any pertinent topics that arose in later interviews.

Memos were made of the data at all stages of analysis. Strauss and Corbin (1998a: 218-220) identify three forms of memos: code notes, theoretical notes and operational notes relating to early coding and analysis, ideas about how codes and themes might start to develop into theory and practical reminders relating to the process. They also state that each researcher will develop their own method of memo writing. In this study, analytic memos (a combination of code and theoretical notes) were made relating to the researcher's analysis of the literal meaning and interpretive feeling within and behind the transcribed data. These built up within each data set and directed the constant comparison of views and experiences within and between transcripts. qsr NUD*IST enables all these memos to be developed, prompting the researcher when a new memo might be required. However, it does not prompt the development of existing memos. This was not a problem in this research, as adding to existing memos became a routine part of the analysis. Dating each memo enabled the researcher to track the development of themes, concepts and theoretical ideas that contributed to the development of the final key concept.

Interview data was read and re-read and coded line by line to extract codes and themes that were then organised into sub categories and categories. More in-depth analysis including the identification of phenomena, defining of categories, conceptualisation and axial coding was undertaken using the principles of grounded theory methodology (Strauss and Corbin 1998a). Preliminary theory development and models began to emerge from the analysis. One sub category is presented in depth to illustrate the methodological process and appears at appendix 3.4.

3.8 Methodological Rigor

Methodological rigor was sought through appropriate sampling, an exploration of truthfulness and the use of reflexivity.

3.8.1 Sampling

Purposive and theoretical sampling methods were used in this research.

3.8.1.1 Sampling for the Pilot Study

Purposive samples were identified for the pilot study. Male and female physiotherapy clinicians of varying grade and experience, all working with older people in a single NHS acute and community Trust were invited, via their manager, to take part in three focus groups. This Trust was chosen for geographical convenience and because it employs a large number of physiotherapy clinicians working in all areas of older persons' rehabilitation and was likely to produce a broad range of experiences. Similarly purposive sampling, identifying acquaintances or relatives of acquaintances, was employed to identify older people who were previous physiotherapy patients. This sampling differed from the theoretical sampling used in the later stages of the subsequent studies in that it only reflected the purpose of the pilot study, which was to ascertain whether these groups felt a relationship existed and was a topic worthy of investigation. This data was analysed using a content and thematic approach for which purposive sampling is sufficient (Smith, 1995).

3.8.1.2 Sampling in the Main Studies

Corbin and Strauss (1998) see theoretical sampling as one of the underpinning tenets of grounded theory approach. The principles of theoretical sampling were used, where possible, to obtain participants in the main studies in this research. Silverman (2000: 105) states that the term theoretical sampling is often used synonymously with purposive or purposeful sampling. Coyne (1997) suggests that whilst sampling in all qualitative research is purposeful, there are many different kinds, of which theoretical sampling is one. However, Silverman (2000: 104-107) notes that true purposive sampling is defined as choosing cases that are likely to illustrate some feature or process that the research

seeks to explore whereas theoretical samples are theoretically defined. Theoretical sampling is further defined as "constructing a sample which is meaningful theoretically, because it builds in certain characteristics or criteria which help to develop and test theory and explanation" (Mason 1996: 94). In practice, this involves identifying data sources that will enable the researcher to explore, develop or test the concepts that arise from analysis of the earlier data. It is accepted that initial data sources will be purposive in order to identify initial concepts. As well as being theoretically defined, theoretical sampling also means being flexible about the sample size as the research progresses in order to adapt to these requirements (Patton, 1990:183-186; Coyne, 1997; Morse, 2000). However, Mason (1996) warns against including participants simply because they are likely to support the evolving theory and this involves avoiding overt researcher or other individual (e.g. service manager in this study) bias. It also requires the inclusion of deviant or "negative" cases (Silverman, 2000: 107; Strauss and Corbin, 1998a: 212). These are defined as extreme examples of variation in a concept and are required to ensure that data is fully saturated with a full range of perceptions and experiences within each concept and category.

The role of theoretical sampling in the development of emerging concepts in GTM is clear (Strauss and Corbin, 1998a). Corbin describes it as "data-gathering driven by concepts derived from the evolving theory and based on the concept of "making comparisons.... that will maximise opportunities to discover variations among concepts and to densify categories in terms of their properties and dimensions" (p201). In grounded theory, theoretical sampling is therefore cumulative and builds on each data-gathering incident. In practice, the constraints of Local Research Ethics Committees and Health Service set-up and delivery mitigate against these purist ideals. These dictate that the size and characteristics of the sample must be pre-defined in order to be subjected to rigorous ethical examination and ensure the minimum of disruption to the delivery of health care. In order to balance the theoretical and practical requirements, the characteristics and numbers of the samples for this research had to be identified prior to the start of each study. The concept of concurrent sampling and analysis guiding data collection had to be compromised in this research. The implications of this in this

research are discussed in Chapter 7. There was some flexibility in identifying individuals who fulfilled these criteria as the studies progressed, ensuring that appropriate samples were achieved. Glaser (1978: 37) would describe this method as selective sampling, the sample being identified "according to a preconceived but reasonable initial set of dimensions such as time, space identity or power which are worked out in advance for a study". Strauss and Corbin (1998a) concede that pure theoretical sampling may need to be modified to reflect "access, available resources, research goals and the researcher's schedule and energy" (p204). However, this did not preclude the inclusion of some negative cases. An example of this occurred in the Physiotherapy Clinicians' study. It became clear as the data gathering progressed that, although each participant recognised that a physiotherapy clinician/older patient relationship existed, they portrayed it as sitting along a continuum described by level and depth of engagement. Physiotherapy clinicians who functioned at the extreme ends of this continuum (purely professional relationship and personal relationship) were actively sought having been identified through previous casual observation of clinicians during the setting up of the research. These views were included to enrich this emerging category and more clearly define its properties and dimensions.

The sampling in these two studies reflected the need to explore the relationship that developed between physiotherapy clinician and older patient from the perspectives of physiotherapy clinicians and older patients. To ensure a broad perspective, the samples were drawn from two geographical areas. These were chosen from the theoretical perspective to include the views and understandings of people having a range of demographic characteristics (gender, social class, age), experiences (previous experience of disability or older person's physiotherapy treatment, good/bad experiences) and expertise (breadth of knowledge and skill). As key themes arose from the early data analysis, participants considered most likely to be able to explore these themes were actively recruited through discussion with potential participants in the relevant physiotherapy departments. There was also a deliberate attempt to ensure inclusion of "negative" cases and obtain a wide range of views. It was theorised that participants with these characteristics would have different experiences to bring to the research. The

practical perspective of geographic convenience was also important to keep the research within time and budget.

The inclusion criteria for the initial interviews in the Physiotherapy Clinicians' study took work place, gender, professional grade and experience into account. This was to ascertain the range of perspectives from men and women, qualified physiotherapists and physiotherapy assistants working in different units and Trust cultures. Initially it was decided to randomly select individuals who fell into each of these categories to prevent any researcher bias created by prior knowledge of some possible participants. However, the changes within the Trusts and post vacancies meant that the populations were too small (other than in the physiotherapy assistant category) to allow this. In the event, early physiotherapy assistant participants were actually identified through opportunity sampling due to service constraints. It was felt that some methodological rigor had to be compromised in order to maintain good relations with these busy services. Sample size was dictated by time and service constraints, advice from supervisors as to when data was likely to be saturated and previous examples of grounded theory methodology (sample sizes in the grounded theory approach studies identified from the literature search described earlier in this chapter (3.2) ranged from 3 –27, median 8). Theoretically, sampling continues until data saturation is achieved and this would have been reflected in numbers of participants included had ethics committee restrictions allowed. In the event, it would appear that the fifteen participants included in the Physiotherapy Clinicians' study did allow for data saturation, mitigating this less than rigorous approach.

Creating a theoretical sample of older people to participate in the Older Patients' study had similar constraints from ethics committee and service requirements. A broad range of inclusion criteria was identified to take demographic factors, pathology, length and place of delivery of the episode of physiotherapy care into account (see appendix 5.2 Older Patients' Perspectives Study theoretical sample inclusion criteria). Ideally this sample would have been identified by the researcher in isolation from any influence from treating physiotherapy clinicians. However, ethics committee requirements dictated that patients be identified and approached during their episode of physiotherapy care, via the

treating physiotherapist. This meant that not only did treating physiotherapy clinicians suggest possible participants fulfilling the criteria but they also, being aware of the nature of the study, had the opportunity to influence the views and experiences of those patients. This possible bias towards both the sample and data and is discussed further in Chapter 6, Perspectives of Older Patients.

Similar sampling techniques were used to identify cases for the final observation study. In this study it was the cases that were sampled rather than the participants as the experience of individual relationships was under investigation. The purposive sampling criteria are at appendix 6.4. The first three cases adhered to these criteria but after these were analysed it became clear that areas needing further exploration included encounters where the relationship was not so good and those where a physiotherapist with little experience in the field of older persons' rehabilitation was involved. Various potential cases were discussed with physiotherapy managers and a suitable case that fulfilled both these criteria was found.

3.8.2 Truthfulness

The rigour of qualitative research is measured by the truthfulness, consistency, theoretical generalisability, transparency of the sampling, data collection and analysis methods and through researcher reflexivity. In these studies, truthfulness is established through the constant comparative method, deviant case analysis (Green, 1998; Silverman, 2000) and assurance of the validity of data generation methods and interpretation (Mason, 1996). This is established through an audit trail. Truthfulness is also judged through consideration of the honesty of participants' responses (Wengraf, 2001). Although this could be seen to contradict the need to value the participant's account, there is still a need for the researcher to assure him/herself that the account does reflect the actual understandings and experiences of the participant and is not a fabrication to please or confound. There is no reason to assume that participants in the Physiotherapy Clinicians' study were not giving honest responses. Indeed, the findings showed similarities between participants and had resonance with the clinical experience of the researcher enabling truthfulness to be assumed. Mays and Pope (1995) advocate respondent feedback to

presentation of initial findings to test the findings. As part of this study, the findings were reported to two focus groups comprising specialist physiotherapy clinicians some of whom had taken part in the study. Focus group participants had no argument with the analysis and added further examples and interpretation (see chapter 4) giving both an assurance of truthfulness and continued development of the theory (Strauss and Corbin 1998b).

Operationally, such feedback was not feasible with the older patient population. Instead the early findings were discussed with older participants in the later interviews and their views on this incorporated into the analysis.

Consistency of data analysis and interpretation is assured through careful transcription and systematic rigorous analysis of the interview data, triangulation of findings against earlier pilot study data and the literature (Barbour, 2001). QSR Nud*ist develops an audit trail which can be reviewed to follow how data was coded and developed into categories and concepts. In this research the audit trail was continually reviewed and the coding frame adjusted to ensure rigor and truthfulness in analysis (for an example see appendix 3.3).

Theoretical generalisability is assured through purposive and theoretical sampling, describing the research setting, the inclusion of deviant cases, the rigorous analysis of data and the testing of developing theory (Mason, 1996). These criteria are all fulfilled in this research and discussed in the subsequent findings chapters.

Researcher reflexivity is essential to establish the impact of the researcher's beliefs and experiences on the research process. The impact of the inquirer in this research is considered below.

3.8.3 Researcher Impact and Reflection

In the constructionist approach the researcher is seen to influence the collection and analysis of data as their background and views are inextricably bound up with choice of

participants within the sample, the emphasis of the interview approach and the interpretation of the data collected (Guba and Lincoln, 1998).

The physiotherapy clinicians' study explored the views of physiotherapy clinicians. As a physiotherapist I had insight into some of the professional and personal experiences that were identified, although the service delivery had changed considerably since I had last worked in elderly medicine in the NHS in 1984. I came to this study with my own opinions as to whether a relationship existed, what it comprised and what made it good or bad. The advantages were that I understood the professional culture and was perhaps able to ask more probing questions. I did not have to spend a lot of time understanding how physiotherapists function within an older persons' rehabilitation setting. There were also some disadvantages. The physiotherapy participants knew my previous role as lecturer and clinical tutor within the university either personally or by reputation and this may have inhibited their responses. In 1984 I left the superintendent physiotherapist post that was filled by one of the participants and I noted some anxiety on this participant's part during the setting up of this interview. However, it was a conscious decision to include this person as part of the theoretical sample in order to obtain the wide range of views sought. This participant voluntarily agreed to take part despite being given the opportunity to decline.

Similarly, the data analysis was undertaken from a clinician's perspective and I had to consciously try to detach myself from this and adopt a more lateral thinking style particularly in the axial coding phase. Strauss and Corbin (1998b) note the importance of maintaining a balance between objectivity and sensitivity. They recognise that some researchers will have considerable knowledge and experience in the field they are researching. They advise openness, giving voice to respondents and recognising that despite apparent similarities, the respondents' values, culture and understanding may be very different. They suggest that examining the properties and dimensions of the data can help the researcher to gain new perspectives. In this study these techniques were used to examine familiar scenarios from new perspectives. In addition lateral thinking

was employed to consider the differences and similarities between therapeutic and other relationships in the light of participants' responses.

Such close empathy with the topic was not the case in the older patients' study, as I have no experience of being an older patient accessing physiotherapy services. My concern here was that my physiotherapy background would compromise my interviewing skills and that the research interview would become a clinical consultation. In order to minimise this I decided to introduce myself to this study's participants as a researcher rather than a physiotherapist and boundaries were identified with the respective senior physiotherapy managers about how I would deal with possible clinical issues that might arise during my visits. In some respects my previous experience in elderly medicine is an advantage in that the experiences described by older patient participants are familiar to me. Being aware of the service process I can prompt people on relevant topics. I am familiar with meeting and communicating with older patients in their own homes. This includes familiarity with the home conditions within which some older people live, something that might be a distraction to a researcher without that prior experience.

During the final, observation study I also presented myself to the older patients as a researcher whilst most of the participating physiotherapy clinicians knew my clinical background. Observing the treatment sessions I had to ensure that I was concentrating on the physiotherapy clinician/older patient interaction and not the clinical aspects. As a health care professional it is difficult to divorce oneself from the clinical care. However, I was able to draw on some previous experiences of researching families with "at risk" children in a social services research environment and could recall the detachment I felt being in a purely research rather than an intervention role. Further reflections on researcher impact and responses are included in the following chapters.

3.9 Summary

This thesis describes an explanation of the relationship that develops between physiotherapy clinicians and their older patients. A constructionist approach was taken across three studies to explore the experiences and perceptions of physiotherapy

clinicians and older patients through individual interviews and, in the final study, observation of treatment sessions. Grounded theory methodology informed the sampling, data collection and analysis. Methodological rigor was sought through appropriate sampling, truthfulness and reflexivity. The following chapters describe the findings of these studies and a discussion of the models that arise from them in response to the research question "What is the essence of the physiotherapeutic relationship in older persons' rehabilitation, including the experiences and perceptions of physiotherapy clinicians and their older patients of the constituents, role, value and impact of the therapeutic relationship that develops during medium to long term rehabilitation?"

Chapter Four

The Therapeutic Relationship: Physiotherapy Clinicians' perspectives

4. Introduction

This study was undertaken between April and July 2001.

Fifteen individual semi-structured interviews were conducted with physiotherapists and physiotherapy assistants currently working in older person's medicine units in two geographical areas. Substantial health service reorganisation was taking place in one of these areas prior to and during the data collection. This impacted on the participant sample and data collection (see Chapter 1.1.4). The interview guide was informed by the main research question, the literature (chapter 2) and the themes that arose from the findings of the pilot study (Appendix 4.1). It developed as the study progressed (Appendix 4.2). Data was analysed using a grounded theory approach (Strauss and Corbin, 1998a). The methodological issues are discussed in Chapter 3, Methodological Approach.

4.1 Aims and Objectives

Aims:

To explore the views of physiotherapists and physiotherapy assistants working in older people's medicine with regard to:

1. Whether a relationship exists between physiotherapy clinicians and their older patients.
2. Whether such a relationship could be deemed therapeutic.
3. The rationale for such a relationship.
4. What such a relationship comprises.
5. The course of the relationship.
6. The factors that impinge on such a relationship.

Objectives:

1. To gain insight into the views, perceptions and experiences of physiotherapists and physiotherapy assistants with regard to the above aims through individual semi-structured interviews.
2. To use the data collected early in this study to inform the sample and interview schedules in later interviews in order to ensure a breadth and depth of participant views.
3. To inform theory development through a grounded theory approach to data analysis.
4. To reflect on personal beliefs and experiences and explore how these impact on data analysis and interpretation.
5. To use these findings to identify further topics to explore with older people in the older patient's perspectives study.

4.2 Participant Population and Sampling

Approval from local ethics committees and NHS service managers was obtained to gather data in the Portsmouth and Chichester areas. During the period when the study was being proposed and set up, these areas comprised two NHS Trusts, Portsmouth Healthcare NHS Trust and the Royal West Sussex NHS Trust. Both these areas provided acute and day hospital rehabilitation services to the older people and had dedicated physiotherapy services for older people. During the health service changes in April 2001 the Portsmouth NHS physiotherapy services redefined into four separate NHS trusts and one primary care group preparing for trust status in April 2002. Two of these trusts and the primary care group provide a range of healthcare services for older people. These providers are mainly defined by geographic area. The physiotherapy clinicians working in these services provide a range of rehabilitation services for older people including acute inpatient, fast track rehabilitation, stroke rehabilitation, slow stream rehabilitation, intermediate care, day hospital, community and domiciliary services. Due to the service changes, several clinicians had gained recent promotion and were in new posts in the newly formed trusts and primary care group (PCG). Physiotherapists and physiotherapy assistants working in these services were invited to participate in this study. A purposive

sample was sought (where population numbers allowed) to ensure a wide range of views from physiotherapy clinicians of different grade, experience, age and gender. Grounded theory methodology requires data saturation to ensure systematic category comparison and enable theory to be generated appropriately (Strauss and Corbin, 1998a: 203). To ensure this, it was decided to elicit the views of sixteen physiotherapy clinicians initially with an option to return to the local ethics committees and physiotherapy managers to seek additional participants should saturation not be achieved. Precedents for these numbers have been established by grounded theorists (Strauss and Corbin, 1998b). Examples are also found in other grounded theory studies (Agee and White Blanton, 2000; Stephenson and Wiles, 2000).

Inclusion Criteria:

The population was limited to those physiotherapists and physiotherapy assistants currently working with older people in outpatient day hospital, community or domiciliary settings within the NHS Trusts in Chichester and Portsmouth. Physiotherapy clinicians working purely in ward settings were excluded as consultation with physiotherapy managers suggested that data gathering would be difficult due to patients being too sick to participate, the greater involvement of relatives and the number of staff involved.

The physiotherapy clinician sample and population are shown at Table 4.1. The actual names of the four participating trusts have been omitted to assist anonymity.

Table 4.1 Physiotherapy Clinicians' Study: sample (and population)

	Trust 1		**Trust 2**		**Trust 3**		**Trust 4**		**Total**
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	
Supt/manager	1(1)			1(1)				1(1)	3 (3)
Senior I		1(1)		1(4)		1(2)		1(3)	4 (10)
Senior II		1(1)		1(1)		1(2)			3 (4)
Junior				1(1)					1 (1)
PTA		1(1)	1(1)	1(10)		1(1)		*(1)	4 (14)
Total	1(1)	3(3)	1(1)	5(17)		3(5)		2	**15 (32)**

M = male, F = female, * = clinician invited but declining to participate, (numbers in brackets) = total population

4.3 Data Collection

Data was collected between April and July 2001.

All participants received an information letter inviting them to participate (appendix 4.1) and giving them time to consider the topics. Interviews were conducted with individual participants at a time and quiet place to suit them and their service and were thus usually undertaken outside patient treatment times in physiotherapy offices or booked seminar rooms. Action was taken to ensure that the interviews were not interrupted by phone calls, other staff or patients. Interviews lasted between 35 and 55 minutes, average 45 minutes. All interviews were tape recorded with permission and transcribed.

The initial interview schedule addressed the aims of the physiotherapy clinicians' study (appendix 4.2) and developed over the course of the data collection (appendix 4.3). After each interview field notes were written. These included any pertinent observations, any initial thoughts about the participant's response, views or experiences and any new topics for possible inclusion in subsequent interviews.

The findings of this study were presented to physiotherapy clinicians in two focus groups in order to check for data saturation and test the relevance of the interpretation. Data from these focus groups informed the categories and concepts that are set out below.

4.4 Physiotherapy Clinicians' Perceptions and Experiences of the Relationship

Fifteen physiotherapy clinicians, comprising eleven qualified physiotherapists and four physiotherapy assistants (two men and thirteen women), from the four NHS Trusts were interviewed. All worked in dedicated older persons' rehabilitation services providing outpatient and or domiciliary physiotherapy. They represented 47% of the available physiotherapy population. Although all participating clinicians treated older patients in a variety of settings, twelve physiotherapy clinicians mostly worked in day hospitals and three mainly treated patients in their homes.

Seven themes arose from the initial analysis of the physiotherapy clinicians' perceptions and experiences of the relationship that develops between themselves and their older patients in outpatient and domiciliary rehabilitation settings. These were:

- Existence and course of the relationship
- Constituents of the relationship
- The rationale and value of the relationship
- Professional power
- Pre-existing factors
- Professional factors
- Impact and outcome

These themes are now considered in turn and are illustrated with actual quotes from the participants. Each quote is referenced using the participant code (PTC = physiotherapy clinician) and qsr 5 NUD*IST text units.

4.4.1 Existence and Course of the Relationship

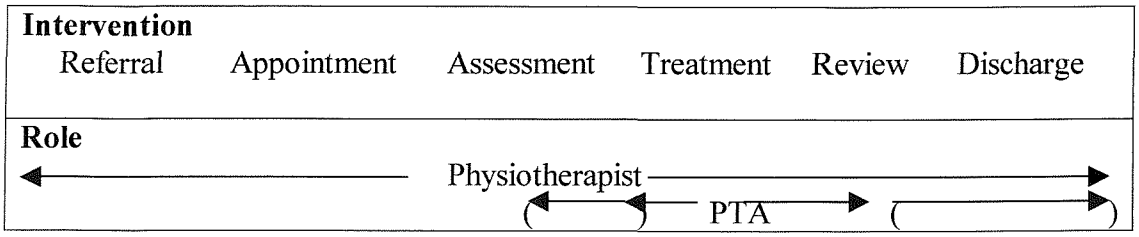
Personal clinical experience, observation and the physiotherapy literature all suggest that a therapeutic relationship exists between the physiotherapy clinician and their patient. This assumption was made in the original research question and appeared to be justified from the pilot study findings. However, as this research depended on the presence of such a relationship, it was important to explore this assumption from the participants' perspective. Their views as to the existence and course of the relationship are discussed below. Some variance between qualified physiotherapists and physiotherapy assistants' engagement with the relationship was found.

All participants were emphatic in the view that a relationship did exist between the physiotherapy clinician and their older patients and that it played an important part in the intervention.

"Yes. I think, in fact, that a relationship is actually fundamental to the therapeutic process" (PTC5: 13-14)

This relationship was felt to differ from other relationships that physiotherapy clinicians experienced with partners, friends or professional colleagues. It had a defined structure that, in the main, followed the course of the intervention (Figures 4.1. and 4.2).

Figure 4.1 The Course of the Physiotherapy Episode of Care

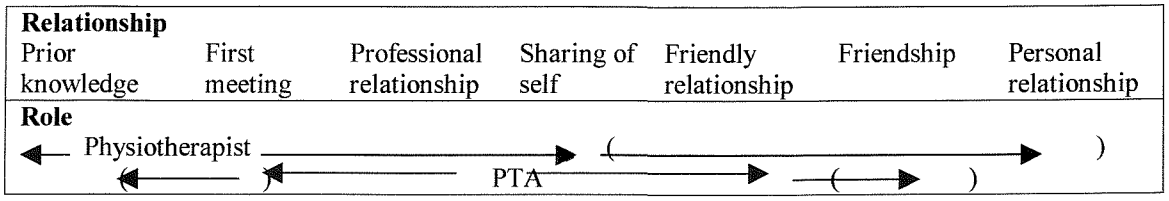


The extent of the role of the physiotherapist and physiotherapy assistant (PTA) in the episode of care is defined by the arrows. The arrows in parenthesis define occasional cases.

All participants described the relationship as one that developed and changed as the episode of care progressed and the clinician and patient got to know each other. Views were expressed about the way in which the relationship started, progressed and ended, the association between the relationship and the treatment intervention.

The therapeutic relationship from the physiotherapy perspective appears to exist along a continuum ranging from professional relationship to sharing of self with some clinicians moving further into a friendly relationship, friendship and on occasion, a personal relationship (Figure 4.5).

Figure 4.2 Levels of engagement of the physiotherapy clinicians in the relationship



The extent of the role of the physiotherapist and physiotherapy assistant (PTA) in the relationship is defined by the arrows. The arrows in parenthesis define occasional cases.

The relationship exists only in conjunction with the physiotherapy episode of care and is seen as a vehicle for the smooth delivery and development of the intervention. In most cases it ends when the patient is discharged from treatment.

Physiotherapists enter this relationship with prior knowledge of the patient from a referral letter, medical records and/or information from other healthcare professionals. This informs and colours their initial expectations of the patient and establishes the professional hierarchy very early on.

"I like to know [the] background of what the person's like perhaps say, to get a picture, say if they were very active. What I try to do is say, when I assess them, I give them a summary of what I think their problems are and what we're going to be doing together to try and work through them and where I think they're going." (PTC 10: 37-43)

The physiotherapists lead the relationship through introduction and establishing the reason for their involvement. This continues with the clinical assessment that is seen as the start of the therapeutic intervention. The physiotherapy assistant is usually restricted to carrying out the prescribed treatment but in some units they may be involved in the formal assessment and discharge of the patient. During this initial period physiotherapy clinicians feel they gain an insight into the interests, lifestyle and priorities of the patient. This, they feel, assists with goal setting and identifying the best approach to facilitating treatment and compliance. By this time physiotherapists consider that they have a good idea as to how the relationship and the intervention are going to proceed and adapt their approach accordingly.

"I think we adapt and we move the relationship depending on the response we get from the patient so it may well be that if we detected an anxiety umm in the patient we may move from the professional to the more personal level and that's totally appropriate umm, but I think it's appropriate so long as it stays within certain boundaries umm and

as long as the objectives of the intervention and the desired outcome for the patient is kept in focus." (PTC5: 173-179)

All parties involved in the relationship were felt to influence the make up of the relationship. Rehabilitation of the older person invariably involves the patient's family and participants felt that the relationship they had with patients often paved the way for greater compliance from the family with treatment and at discharge. The relationship with patients was felt to differ from that with relatives, being one stage removed, with the patient being the primary person in this situation with their goals and needs paramount.

"Umm, probably I would say it's a much less close relationship. The relative umm... in some instances, of course, you have to try and edge the relative away because they're either trying to be over protective or they're trying to answer for the patient all the time, whatever. And so you can end up with a, actually quite a close and friendly relationship with the patient themselves but with the carer or relative whoever, might actually might be not feeling all that sort of happy because you've actually edged them away a bit." (PTC8: 545-553)

Qualified physiotherapists, specifically the more experienced seniors working in day hospital environments, were more likely to take a professional stance, feeling that patients expected a clinical approach. They felt this protected them against getting too involved, allowing them to impart information that might be difficult for the patient such as discharging them from physiotherapy when the patient may feel they have yet to achieve their full potential.

"One of the challenges for us [qualified physiotherapists] I think in managing more chronic conditions ... is the need to have a focus on the need for intervention and perhaps to use a tool such as goal setting to that end. Now, I think that works well where the relationship is professional and stays in that domain." (PTC5: 130-134)

However, they expected that their assistants would develop a more friendly relationship with the patient that allowed more personal information to be exchanged.

"I think they [qualified physiotherapists] probably tend to have a more professional relationship but that doesn't mean to say it's always a more effective relationship and we know, again from our experiences, that, umm, one of the strengths of our physiotherapy assistants is in the relationship they develop with patients. Umm, in some ways I think that's due to the model that we work to now where in many instances physiotherapists will carry out an assessment, agree a problem list and plan, umm, around agreed goals with the patient, but a lot of that care is, in effect, delivered by physiotherapy assistants. So they spend increasing amounts of time with patients." (PTC5: 379-387)

Physiotherapy assistants also believed this to be the case and passed information from patients back to their seniors. It is not known whether the patients know this is happening or whether they collude with this.

"Because I often... I think that a patient might tell me, sometimes, not all the times, more than they might tell the physiotherapist because I'm the one that chats to them maybe on not quite such a professional level and they sometimes seem to unburden themselves a little bit more so that I can pass that on." (PTC3: 26-30)

Physiotherapy assistants saw themselves as functioning within the middle of the relationship continuum being more prepared to share personal elements of themselves and move towards a friendly relationship. Some physiotherapy assistants believed that they moved beyond this to an active friendship but others felt it was not their role to be a friend. This depended more on their personal beliefs than patient factors such as willingness to engage in a relationship, the length of the episode of care and the reason for the physiotherapy intervention. It also depended on participants' definition of the term "friendship". In all cases, the amount a physiotherapy assistant was willing to share him or herself varied according to how they felt they got on with the patient.

Some qualified physiotherapist participants differed in the amount of self they were prepared to share with the patient.

"I think it's difficult to be effective and communicate with a patient and be really empathising with them unless you've identified with them and relating to them and develop some empathy with them." (PTC11: 12-15)

"I share with them whatever I feel is appropriate for the situation that I'm in and depending on the nature of the patient." (PTC13: 142-143)

One physiotherapy assistant described moving into the friendship/personal relationship end of the continuum and one physiotherapist described some relationships with patients that had progressed to long-term friendships lasting well beyond the end of the episode of care. These instances were unusual within the data set and are regarded in Grounded Theory Methodology as negative cases (Strauss and Corbin, 1998a: 212). These are defined as the perspectives of the minority of participants that denote extreme examples of variation within a concept.

4.4.2 Constituents of the Relationship

Physiotherapy clinicians identified three key constituents to the relationship: interpersonal skills, engagement and respect.

Interpersonal skills included verbal and non-verbal communication skills, empathy and the use of humour. The ability to communicate with the older patient was felt to be absolutely vital in gaining trust.

Professionally, communication skills were felt to be used by the physiotherapist or physiotherapy assistant to introduce themselves as a clinician, to identify the key areas for intervention through careful and probing assessment and to ensure clear, accessible explanations of clinical intervention and management. On a human level, communication skills of listening and empathy with respect were considered vital to

engaging with the person behind the patient and in allowing the patient to see the person behind the physiotherapist.

The participating physiotherapy clinicians also used social skills to optimise the relationship. These included engaging with the patient at their level of interest to obtain information that would help to get the patient to participate optimally in their treatment.

"I'll often use reference from home and from things that they know like if it's a gardening type scenario saying 'We need to get you perhaps from a Zimmer frame because it's not going to be terribly easy to use in the garden on the grass, let's try out some sticks.' That kind of gives them an incentive to participate and they know where they're going." (PTC14: 207-210, 216-217)

Humour was used in a variety of ways to engage with the patient, establish rapport and encourage them within the intervention. All participants felt they used humour in a sensitive way, often testing the patient's response before using humour in an explicit manner.

" ...most patients like to have bit of a joke and a laugh. I mean to be honest, I think that their lives have often been very serious and very medically orientated and if you can just lighten it a bit I think that in itself... I mean humour in itself seems to go a long way to helping patients keep things in perspective. (PTC4: 605-610)

The key constituent engagement includes the depth and extent of the relationship, building confidence, negotiation and goal setting and working towards patient partnership.

Negotiation skills were felt to be important in goal identification and prioritisation and a degree of sensitivity was required to ensure that information was handled and imparted appropriately. The ability to build confidence in older patients was considered key to both

the relationship, in that it empowered patients to share in goal setting and in the intervention, where it optimised patient engagement with their physiotherapy programme.

Partnership was seen to be the gold standard for engaging patients in their physiotherapy treatment and a good relationship was seen as crucial to paving the way to this especially in a client group that, in the main, expected to be told what to do by healthcare professionals. Participants felt it important that the patient engaged with them both as a person and as a physiotherapist, suggesting that engagement with physiotherapy treatment was easier if the patient had a good relationship with their physiotherapist. They felt the relationship needed to be a shared experience for both clinician and patient and were prepared to take the time to ensure that the relationship had the potential to develop the ambience for a clinical partnership to develop.

"I probably stop whatever they think we are going to do and just sit down and chat to them and talk to them about what they want to do and what's required for the next move perhaps in their state of ability and see if, you know, you can get them on your side rather than... and then try again. And tell them that you're not going to rush them or push them. We just want to know what they can do and then improve it." (PTC1: 81-86)

Having some insight into the personal life of the patient through a good relationship also enabled the physiotherapist to choose the most appropriate strategy for encouragement and broke down the professional/patient gulf facilitating more equal partnership.

"I think it helps to identify areas of sort of common interest and feel that we're not separated by this huge gulf of patient/physiotherapist or patient/ hospital, that we're actually working together and we're forming a team rather than I tell patient and patient asks me and to make it more a sort of exchange and a sort of meshing sort of relationship rather than a sort of two brick walls up against each other." (PTC14: 172-177)

Participants reported actively cultivating the relationship they had with their longer term or multi-pathology older patients. A good relationship that fully engaged these patients

on health, personal and family levels was felt to be key to obtaining the information needed for optimal intervention and assisting the patient to make any necessary lifestyle changes.

"Within the relationship the patient's roles and responsibilities in achieving that outcome can be agreed and they can be engaged completely in the process because I think the partnership needs to be there not just in terms of agreeing the outcome but in getting there and yes.... Particularly for those patients for whom the outcome requires ongoing changes or behaviour modifications which may mean for them lifestyle changes... I think the partnership is required to make that happen." (PTC5: 220-230)

Where a relationship was poor, partnership was deemed more difficult to achieve with less sharing of information and a reduced likelihood of the physiotherapy clinician being able to fully identify the patients' needs. In this case, participants believed that goals and outcomes were more likely to be professionally rather than joint or patient led.

"I think with patients with whom the relationship isn't as good , the outcome.... I would think in those patients the outcome is more likely to be a professional directed outcome rather than a patient directed outcome. And those two might be quite different so it may be a reasonable outcome for the professional, or a good outcome but I would probably question whether it was really the desired outcome for the patient." (PTC5: 209-215)

Several participants expressed a concern that too intense a relationship could make the patient dependent on the clinician.

"T*hey mustn't become too dependent on you because you are making them...helping them to continue to live in their own life. So you don't want to get too dependent.*" (PTC1: 213-215)

The key constituent respect includes the mutual respect and building of trust felt to be fundamental to a good relationship and engagement with treatment.

Trust was a key theme running through the data and felt to ensure a good physiotherapy clinician/older patient relationship. Physiotherapy clinicians felt it vital to instil trust in their patients to enable goal setting and compliance with the intervention.

"I think one of the first things you've got to do is build, very quickly, build up a relationship where they're going to trust you. I think trust is maybe one of the important factors." (PTC6: 30-31)

"Well, again, we're back to trust. Umm, I think trust is probably one of the biggest, biggest factors because if they don't, even if they're sixteen or twenty-six, thirty-six, sixty, they're not going to respond to what you're asking them to do. So trust I think is the key in my opinion." (PTC15: 158-161)

4.4.3 Rationale and Value

Rationale: All participants identified reasons for having a relationship with their older patients. These included facilitation of information gathering, promoting engagement with physiotherapy as well as the physiotherapist and as a vehicle to establishing partnership and facilitating goal setting. A good relationship was also seen as having value to clinicians, patients and the service. In particular, physiotherapy clinicians valued the personal and job satisfaction that a good relationship afforded.

Participants felt the rationale for developing the best possible relationship was to engender an atmosphere of trust creating the best conditions for a patient to be able to confide any fears or anxieties.

"I am surprised how apprehensive sometimes they can be when they first arrive. And I've had on several occasions somebody say "Oh I really enjoyed that and I've been worrying about it all night long". I mean I know it wasn't all night long but they have said things like that and "I've enjoyed it". So it is, so until you tell them what you want or until they see what it's like here they often are quite worried." (PTC3: 97-102)

A good relationship was deemed essential if the patient was to engage fully with treatment.

"You need their co-operation, motivation so you have to foster a relationship in that respect to enable you to be able to motivate them." (PTC10: 31-33)

Value: In addition to its rationale, the relationship was also valued. Physiotherapy clinicians valued a good relationship as they gained personal satisfaction from it and although there was no evidence of physiotherapists striving purely to be liked, they described their approach to patients as friendly and open with professional overtones, an approach most likely to encourage patients to like them.

"But as soon as the patient comes on the ward I always introduce myself, go and see them, make the effort to go and see them. Wait 'til they've settled in, had all their admission check and everything, then I go and see them, let them know who I am and what's going to happen." (PTC12: 36-40)

They expressed feelings of disappointment, frustration and failure if they perceived the relationship was compromised when a patient did not engage with them.

"I mean I can remember treating a patient recently who... I was at my wits end trying to discuss with this very disabled person, you know, sat down... very poor sitting balance, miles away from being able to do this [walk independently] and had been for some time. And I remember saying "It's about probability. If you look at buying a lottery ticket, you have a one in fourteen million chance of winning. It's very unlikely." But he said "Oh yes, I know I will win the lottery one day." And the whole attitude to life was so unrealistic and then I was like... then I get frustrated and I think "Oh, for goodness sake"." (PTC13: 598-613)

The quality of the relationship was seen to impact on the clinician with a good relationship giving participants a feeling of job satisfaction.

"I mean perhaps I feel happier in that perhaps I'm a doer and I feel that I'm able to do something positive and practical with somebody. And I think the patients also feel that they... if they are able to do something and achieve, then they feel quite positive about it." (PTC9: 310-314)

Participants recognised that the relationship had specific worth to older patients who may have little prior knowledge of current health services and concerns related to earlier health care experiences. The relationship was felt to benefit the older patient, through putting them at ease, establishing trust and facilitating information exchange.

"I think inevitably, particularly with the elderly you actually require patients to develop a trust and understanding in connection with you because initially I think a lot of people are very wary, some of them have had very little dealing with the Health Service and umm, to be honest, I think, until you build up the relationship you don't get a full picture of patients' needs." (PTC4: 12-17)

The value of a good relationship was deemed to have physical as well as emotional benefits combining to produce a positive experience for both patient and physiotherapy clinician.

"Once the... the relationship is developed and trust is established they are just so easy to treat. Because instead of lifting them up they are standing up for you, anxious to help you." (PTC2: 320-322)

Participants felt that the relationship helped the patient to see their physiotherapist as human, engendering more trust and confidence than professional qualifications alone. This in turn affected the patient's likelihood of complying with treatment that may be difficult, hard work or uncomfortable. One physiotherapist described her relationship as a kind of camaraderie, of "being in this together".

"I think if a patient feels they can get to know me and even like me umm it makes for a comfortable, happy sort of relationship and physiotherapy is maybe less of a chore and if it gets tough that they feel, you know, we can carry on, we can sort this out." (PTC14: 196-201)

Participants also felt that patients benefited from a good relationship in the same way that they did, it being human nature to want to like and be liked.

Value to the health service was also felt to come from a good physiotherapy clinician/older patient relationship. Although participants could not provide hard evidence of this, their perception was that a good relationship enhanced patient compliance and had the capacity to speed recovery.

"I think patients I can develop a good relationship with... I think our treatment's more likely to be successful. Umm... the patient will understand where they are, how we function together, that we have goals and what we're working towards and that the patient understands that I'm working for that patient's benefit, I'm not setting arbitrary goals and we're working towards a final outcome, the final goal and that we're doing that together and that's something that the patient has determined and I'm helping and supporting them in that. (PTC14: 181-188)

Participants also gave examples of where poor relationships affected the morale of physiotherapy clinicians and the multidisciplinary team. Similarly complaints were felt to arise more often from situations where communication and relationships had been poor.

4.4.4 Professional Power

Participants recognised a hierarchy within the relationship that could put the patient at a disadvantage. The physiotherapy clinicians saw themselves as having the power in the initial stages of the relationship, seeing the patient as disadvantaged by being in a foreign

environment, often without their own clothing, feeling ill or frail and having the false expectation of being "done to".

"And when people come in to this department a lot of them are dreading, whether it's on the wards or the outpatients "what are they going to do to me?". And I think you have to identify that as well, that there's a fear in that person and you've got to try and make them feel comfortable first." (PTC7: 394-398)

Pre-existing beliefs about hierarchy inherent in the health service institution were felt to impact on the clinical intervention. The relationship was always initiated and usually terminated by the physiotherapy clinician at the end of the episode of care, and although they aimed for equal partnership to direct the course of the intervention they were unclear as to whether this actually occurred and, if it did, whether that constituted a shift in the balance of power within the relationship.

"I think it's the skill of the practitioner to try and guide that process, but guided in a way that allows the older person to be part of it - as opposed to being totally directed by the practitioner and I think that's the real skill. I think there's ... for intervention to be really successful for goals to be achieved, there needs to be a real sense of partnership. And I think that's only achieved if the older person is supported in being part of that relationship and is encouraged in that direction from the very beginning. Umm, and that's where the relationship comes into it." (PTC5: 79-87)

However, some participants felt that sharing power through partnership was not always an option that the older person wanted.

"...but some patients, you will never get them to take control of the rehab process no matter how hard you try." (PTC13: 331-332)

Participants felt that the issue of institutional power took a particular slant in older person's medicine noting that older people had grown up in a less questioning age, more

accepting of the medical establishment. Participants felt that as their generation aged they would take a more questioning stance and be more willing to take a proactive role in their own healthcare.

"It will be coloured by the perceptions that [the] older person has of the roles of those people and whilst I think we're moving away from the generations who place their consultants on a pedestal I think there is certainly an element of umm, of distance between older people and medical practitioners." (PTC5: 288-292)

4.4.5 Pre-existing factors

Participants identified various factors that were intrinsic to the physiotherapy clinician / older patient encounter that had the potential to impact on the relationship. These were in addition to specialist professional skills. These factors included the pre-existing personal beliefs, attitudes, socialisation and experiences of both the older patients and physiotherapy clinicians, the frame of reference within which the intervention is delivered, gender, professional grade and experience in older persons' medicine and the environment within which the intervention occurs. These factors are also illustrated by participants' explanations of what makes a relationship good or bad and through their views of the specific characteristics of relations with the older age group. Some service issues were also felt to impact on the relationship, clinical intervention and outcome.

The personal characteristics of both physiotherapy clinicians and older patients were felt to be an intrinsic factor that influenced the relationship and engagement with the intervention. Although the majority of encounters were seen to be good some were felt to be compromised.

"You do have the odd character that you really don't get on with don't you, I mean, in life as well." (PTC1: 380-381)

Factors such as patients' limited compliance with treatment and personality clash were felt to contribute to poor relationships. Physiotherapy clinicians felt confident that these

problems originated with the patient as poor relationships with patients were not a common problem in their daily work and other staff working with these patients reported similar difficulties.

"There's one who was a very aggressive man. He'd do everything to try to antagonise me. He'd try to find where I would break and snap and he tried all the avenues and it didn't work.... You've got to stay professional as much as you can be when in that situation. And it is difficult at times." (P8: 77-80, 82-84)

"There may be an older person who umm, has a particular personality, a particular type of behaviour which makes it more difficult for them to form a relationship umm as part of the therapeutic process, despite the best efforts of the skilled practitioner ...to engage them." (P1: 342-345)

However, participants appreciated that their personal characteristics also had the capacity to impinge on the quality of the relationship.

"It's the personality bit I think. But it can make or break a treatment. It's just so vital." (PTC2: 497-498)

Other factors leading to poor relationships were patients having outspoken views in contention to those held by the treating physiotherapy clinician such as racist or sexist attitudes. Participants felt that little could be done to mitigate these factors and dealt with them by withdrawing from the situation either by referring them to another physiotherapy clinician or withdrawing into a purely professional stance and reducing treatment time and length to an absolute minimum.

"I mean you have to be honest about this. If you have somebody that you really don't do too well with it's probably as well to swap, to ask another therapist to see them." (PTC8: 324-326)

Other patient related factors were more likely to seen sympathetically and worked around. These included patient reluctance to engage due to poor physical or mental health, cognitive problems and unrealistic expectations.

"I mean, I find it quite difficult to deal with certain people... people who are of a depressive frame of mind and whatever you suggest to them it's "Oh no, I can't do that", you know, that sort of person. Umm, it's difficult to build up a good relationship with some, you have to work at it a bit." (PTC8: 315-318)

Rarely the reason for a poor relationship was seen to stem from the physiotherapy clinician. These reasons were mostly considered to be extrinsic to their persona but included inappropriate timing and approach and lack of experience.

"I think it [a poor relationship] could be [due to the physiotherapist], yes. I think if the therapist isn't a particularly good communicator or they may have had a bad day or whatever and they might not feel generally chatty..." (PTC10: 482-483)

Sometimes poor relationships improved as the episode of care progressed. Early problems were mainly deemed to be due to service constraints, in particular early on when the patient was anxious.

"I mean.... if people are very stressed on an initial visit, perhaps they've had a lot of tests and things and they're a bit intolerant." (PTC4: 172-174)

The underpinning approach or frame of reference within which the clinicians practised was felt to influence the relationship. Most physiotherapy clinicians in this study described a holistic, psychosocial approach rather than a reductionist, medical model route. All described a personal philosophy that underpinned their approach to their older patients. Seeing and treating the older person as an individual and with respect was the most common perspective along with honesty and treating them as you would like to be treated. One participant felt that her approach was driven by her religious beliefs and

some others referred to negative incidences experienced by themselves or older relatives as motivators to good practice. Some participants related their management of older patients to the way they perceived their older relatives and felt they afforded them similar respect in the clinical arena.

I think that you must treat them as proper people and you must be honest. I am a great believer in honesty. That's my, I'd say that's my main thing. And remember that everybody is a person. Somebody. (PTC1: 566-567)

"My mother was not treated very well when she was ill and in hospital. In fact she was treated appallingly and I said I would never like to see anybody else treated like that and that's why I hope I have this rapport that builds up with patients and that is at a level that they can trust me." (PTC9: 37-42)

One participant felt that her approach was purely informed by her physiotherapy professional persona.

"... you are there as a therapist to improve the patient's quality of life as much as you can in a way that is relevant to them ..." (PTC13: 445-447)

The age of the patient was considered less influential on the relationship than the type of therapy intervention required. Relationships were considered to be more important in the rehabilitation of people presenting with multiple healthcare needs requiring in-depth assessment and longer-term management with therapy geared towards multiple goal achievement. Although this occurs frequently in older person's medicine it was also felt to occur in other client groups such as paediatrics and younger person's rehabilitation units. In all these client groups a good relationship was seen as a precursor to recommending the considerable life style changes required in adapting to disability.

"With the elderly patients, I think that in order to achieve their best results normally you do need to have that trust and it tends to be people... Umm... patients with more complex

problems, which most of the Day Hospital patients have, they have either had a stroke on top of perhaps a fractured neck of femur and therefore it's a sort of it's a very umm holistic problem..." (PTC4: 56-64)

Relationships with patients presenting with single impairments were described as more impersonal. For example, the relationship with patients seen on a single impairment driven intervention such as measurement for a walking aid, was not cultivated to the same extent. Participants described these relationships as cursory and not requiring the same amount of involvement from either the patient or themselves.

" So I think with those patients who are perhaps coming in and out just to be monitored and progressed the relationship is different, dependent on the patient and their needs." (PTC4: 65-68)

Participants varied in their views as to whether the gender of the therapist had any effect on the relationship. Some participants felt that it had little impact. Others felt that gender was influential in individual cases with one male participant holding more sexist views. *"But men [male patients] generally, I try and leave to the ladies [female physiotherapy staff]. Men like ladies. If I was a patient, I wouldn't want me, alright? I'd want some dolly birds coming in to see me." (PTC2: 447-448)*

"Actually I don't think it [gender] makes a difference truthfully. There's odd patients who, perhaps, some of the very brusque men perhaps sort of think "I'm not going to be told by her" but it is very rare. And most of the men it's just a question of them realising you actually know what you're talking about." (PTC4: 387-390)

Professional grade was only found to be an issue in the levels of engagement with the relationship between qualified physiotherapists and physiotherapy assistants as previously identified. Differences in grade within the qualified physiotherapists was less important than age and experience in the field of older person's medicine or other longer term rehabilitation settings. As the age of the treating physiotherapy clinician

approached that of the older patient the potential for misunderstandings between them was felt to be reduced.

"I think your interpersonal relationships with people, especially people of a very different generation develops as you get older. I mean with the elderly, you know, if you can talk about things that happened in the past, if they can talk about it and you can show a little bit of knowledge, a little bit of understanding, I think it helps. It must be quite difficult, possibly, for some of the really young, newly qualified physios you have, like a three-generation gap for the old folks." (PTC8: 264-270)

The community physiotherapists felt that the environment influenced the relationship that developed between them and their patients, feeling that the balance of power had shifted as they were on the patient's territory. They felt that this made them hold back in taking the lead in the relationship but did not think that the patient felt any more empowered.

"It does change. Because when you see them at home you are also a guest in their home. So it does change the balance and you can't just rush in and say "Let's look at your exercises" and rush out again if you're in somebody's home and they want to show you the pictures of their grandchildren. That has to be part of what you're doing." (PTC8: 87-91)

Experienced physiotherapists working in the community had worked with some individual patients for many years and built up relationships that, whilst remaining within the professional bounds in that they existed purely to deliver physiotherapy, were described in more friendly terms. These physiotherapists describe sharing personal information, for example about family on a basic social communication level and not as a means to facilitate treatment or to encourage patient compliance. However, these relationships were more likely to have their boundaries challenged with patients asking physiotherapists to undertake tasks outside of their physiotherapy remit.

"I mean it ranges from simple little things like "Can you post a letter?" "Can you drop my prescription off?" to umm, "Can you talk to the doctor for me about so and so?" or "Can you ask the district nurse to call?" Those sorts of things which are just sort of verging on.... And of course, one of the difficult things is people can get quite demanding if they're lonely." (PTC8: 145-150)

Most participants were adamant that they entered the relationship with older patients exactly as they would with younger patients. However, factors such as the past health care experiences of older people, older patients' fears about health services and the way they might be perceived and treated by virtue of their age were factors that physiotherapy clinicians felt they took into account when working with older patients. Similarly, earlier life experiences and the possibility of more entrenched life styles and behaviours in older people were felt to influence the relationship both positively and negatively.

"I think some of that could be from patients' previous experiences with professionals and healthcare systems. I think that can have a bearing on how they react to you. Umm, I think some of it can be obviously related to their pathology and whether they have a definite diagnosis, whether they're in a lot of pain, and that if they believe you're going to come in and cause them more pain then that can take longer to get over that fear before you can establish the trust. Certainly with this age group you have to know what's gone before." (PTC11: 56-63, 596)

The physiotherapy service for older people was felt to have particular components that set it apart from other health care provisions. These were continuity and time.

Participants felt that the continuity afforded by the relationship between physiotherapist and older person was peculiar to physiotherapy and assisted in the therapeutic process. Participants felt that whereas medical staff were not often available and nursing staff changed shifts, the patients were able to develop a consistent relationship with their physiotherapist with whom they had regular appointments. This was felt to assist with the practical issues of information exchange and to improve trust and rapport. Continuity

of physiotherapist, treatment place and time were all felt to be important. The length of time spent with the patient was also felt to differentiate the physiotherapist/older patient relationships from those of other healthcare professionals. Both the length of time spent with the patient during each treatment and the length of the episode of care were considered important to the development of the relationship and the way in which the relationship could enhance the intervention.

"I think we have the luxury of time. But we have usually one on one or, you know, if there's a helper then, or assistant, then yes, there's three of you. Umm, we have, you know, a good time of therapy talking to the patient, you know. Developing this relationship, you know and working out, you know, what they're like, what they respond to, what their goals are." (PTC6: 408-413)

Most participants felt that occupational therapists had similar relationships with older patients as they had similar requirements for information and patient collaboration in therapy. However, physiotherapy clinicians felt that their relationship started earlier in the episode of care and they may be more established as a key-worker before the occupational therapy intervention starts.

4.4.6 Professional Factors

A number of professional factors were identified that were specific to the physiotherapy clinician / older person clinical intervention associated with healing. Although these were not obviously connected with the relationship, the way in which most physiotherapy practitioners work means that these professional factors can influence and be influenced by the relationship.

The professional components that set the physiotherapy clinician/older patient relationship apart from other clinician/older patient relationships were felt to be touch and specialist physiotherapy skills and knowledge. Other professional factors impacting on the clinical encounter were professional boundaries.

Touch was seen to have several components and certain types of touch were particular to physiotherapy. Other health care professionals were considered to share some of these components. These included social touch such as shaking hands, personal touch such as placing a comforting hand on a distressed patient and care touch relating to personal activities of daily living such as assistance with washing and dressing. Treatment touch, involving a more impersonal kind of clinical intervention such as giving injections or bandaging, was felt to be the domain of doctors and nurses. However, two main types of touch were considered to be entirely within the realms of physiotherapy and of particular relevance in older person's rehabilitation. One was facilitatory touch used in specialist physiotherapy procedures such as stroke rehabilitation where movement is facilitated during treatment. The other was therapeutic touch including such activities as passive movements, supporting limbs during exercise and placing a hand on a muscle to demonstrate where movement is required. Assisting older people to mobilise could be considered a mix of therapeutic and facilitatory touch. Diagnostic touch was felt to be used alongside therapeutic and facilitatory touch as a means of continuous assessment. However, diagnostic touch is not specific to physiotherapy, being used by other clinical professions.

Although participants considered touch to be a clinical and professional skill, many used social and personal touch to facilitate and develop the relationship and pave the way for, perhaps the more intimate, therapeutic and facilitatory touch within the treatment intervention. All participants were aware of the potentially threatening nature of therapeutic and facilitatory touch to the patient and used the relationship to facilitate patient comfort with this. Both physiotherapists and physiotherapy assistants identified using all these types of touch. The type and amount they used depended on the emotional and physical needs of the patient and the role of the clinician, which varied between units.

"I always tend to touch their hand, I don't know, it's just a natural thing I do, I touch their hand or even their leg. And I think that's just a bit of comfort and it's a bit more personal than just standing there in front of them." (PTC12: 55-57)

"It's very intimate and invading their personal space big time, especially with the stroke patients who you have to get in really close and really early and really umm, when they're possibly not understanding what's going on a lot of the time." (PTC6: 496-499)

"I would use the social type of touch if they were crying or something then you would hold their hand or put your arms around their shoulder or whatever. Yes, for me I would perhaps use therapeutic touch quite a lot just purely because of the sort of work I would do, sort of have my hands on the pelvis while we're doing sitting to standing or whatever but in quite a specific way to facilitate a specific activity." (PTC10: 409-414)

Specialist physiotherapy knowledge relating to the use of physical modalities to optimise mobility and function was also felt to distinguish physiotherapy from other health care interventions. Participants felt it was important to establish the role of physiotherapy with their older patients and often used their good relationship to explain this.

"The other thing that I think they need to know is exactly what you can do for them and what your role is in the wider picture." (PTC6: 32-34)

The physiotherapy clinicians all identified boundaries to the therapeutic relationship. These were usually set by the individual clinician and informed by professional codes of conduct, Trust guidelines and personal preferences. These boundaries varied but all related to the length and content of the intervention and the depth of the relationship. In most cases the boundaries relating to treatment (content, timing and length) were explicitly identified and set by the physiotherapist during the episode of care. However, the relationship boundaries were more tacit with the physiotherapist continually making personal judgements about how far the relationship could and should move between professional and personal elements. This might vary between patients.

"There is a limit to which, um, you would go. I mean my patients don't become my friends outside the clinical setting." (PTC4: 418-419)

"There are patients where it can be very easy to blur the edges, umm, particularly if there are differences in expectation between what the patient expects and what the therapist thinks is achievable. Umm... it's difficult because I feel that if you give too much of yourself they feel they know you too well, it can be difficult to have more objective discussions about progress and problems." (PTC13: 147-154)

Some patients were felt to display power within the relationship when they challenged those boundaries. For example, some patients refused to engage with the relationship or the intervention as the physiotherapy clinician expected. Other patients were deemed to be manipulative within both the relationship and in gaining the treatment they wanted rather than the treatment the clinician wanted to give. There appeared to be a fine line between negotiation leading to partnership and patient choice and patient behaviour that participants felt overstepped these boundaries.

"... one little PD [Parkinson's Disease] chap who used to take it upon himself that he wanted to give me a kiss on the cheek umm, just one day I thought "Umm this is getting to the point that this is...perhaps I have to say to someone else ... I just kept my distance so he knew I wasn't going to kiss him and it was fine." (PTC15: 550-556)

Relationships with patients who consistently failed to stay within the boundaries were felt to be bad.

4.4.7 Impact on Clinical Outcome

Timely, appropriate and skilled clinical intervention was considered to impact on clinical outcome in its widest sense. Although cure was considered the ultimate outcome for physiotherapy treatment, participants felt that in older person's rehabilitation this was not always possible and the role of the therapeutic relationship was considered to be important alongside treatment in optimising health gain and quality of life.

"Some of the patients you perhaps have the best relationship with are patients that really

there isn't very much that can be done but they are very grateful for what little can be achieved, that little bit of extra independence, those extra few steps are so vital to them that the relationship is often very good anyway." (PTC4:212-216)

The term therapeutic relationship was familiar to, and used by, all participants. All were happy to use this term to describe the relationship that occurred in the clinical setting with older people although none felt that the relationship was inherently therapeutic in the absence of physiotherapy intervention. However, some participants felt that where older people were lonely they could receive some health gain from the relationship in isolation although this was not specific to physiotherapy.

"A lot of the older folks are, umm, quite lonely and they are looking for more than just therapy. In fact I think in some instances, therapy is quite secondary; they are looking for a social contact." (PTC8: 30-32)

All participants felt that a good relationship impacted on outcome, as communication, co-operation and carry over were better. A good relationship was felt to impact on the quality, choice and speed to achieve outcome. Participants felt that rehabilitation time could be reduced when a good relationship was established, as the patient looked forward to seeing the physiotherapist and could concentrate on the treatment within a mutually comfortable encounter. Similarly, patients were felt to work harder to please the physiotherapist and to have more faith in their clinical abilities when the relationship was good.

"I would say that it makes sense that if you have good relationship with the patient you are more likely to have an effective... you're more likely to communicate with them well. They're more likely to communicate well with you, which is probably more important. And I think you're probably more aware and have a better assessment of the breadth of their needs and that will inform the.. the assessment and treatment process, not just within physiotherapy but within umm the other domains which may in fact trigger

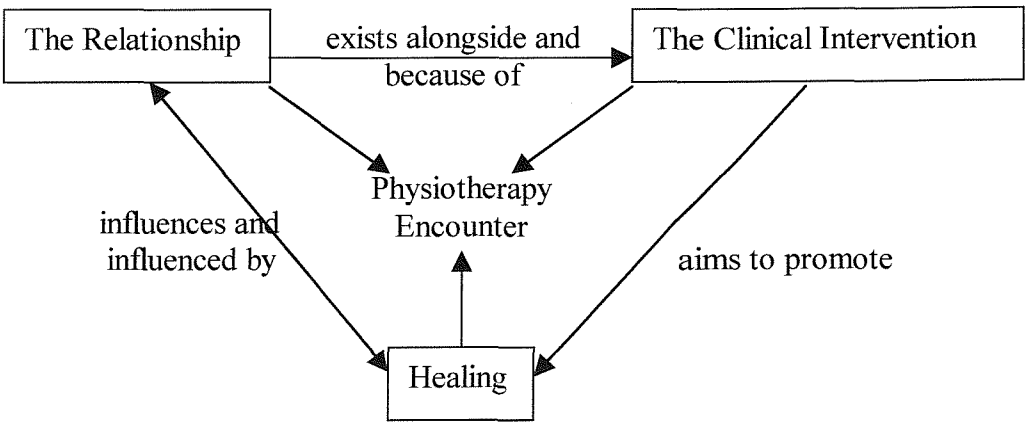
assessment... referral to other agencies. So if the relationship is good the total outcome for the patient may be better because of that." (PTC5: 181-189)

4.5 Conceptualising the Relationship within the Physiotherapy Encounter

Participants identified the relationship as being integral to and influential throughout the encounter. It existed alongside and because of the clinical intervention. The aim of the clinical intervention was to promote healing. In turn, participants felt the speed and extent of healing was influenced by the quality of the relationship. An encounter that comprised a good physiotherapy clinician / older patient relationship, appropriate and timely clinical intervention and effected healing in its broadest sense was considered an optimum encounter and something to strive for. The optimum encounter was described as one that promoted partnership, good clinical outcome and satisfaction for all parties. This is illustrated in figure 4.3 and forms the basis of the first model arising from this research which places the relationship within the physiotherapy encounter from the physiotherapy clinicians' perspective.

The relationship, clinical intervention and healing emerge as the three main categories from the data gathered from physiotherapy clinicians.

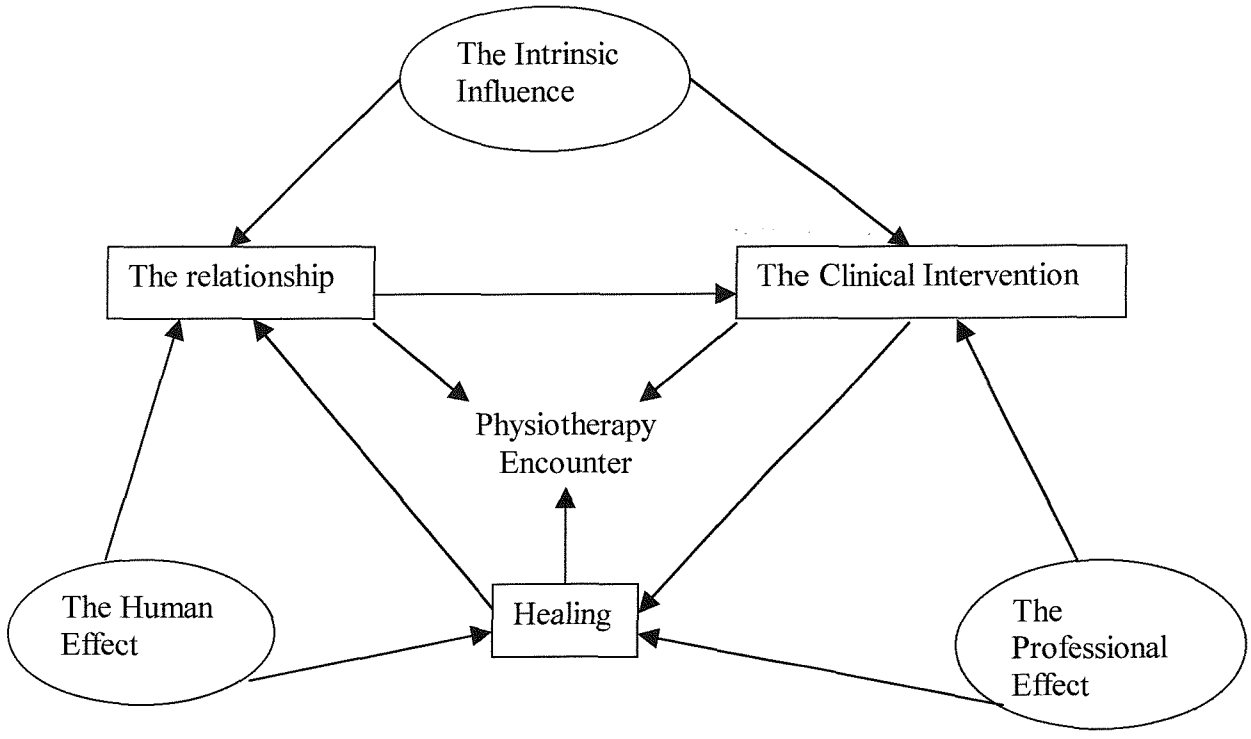
Figure 4.3 Model 1a: Placing the Relationship within the Physiotherapy Encounter



This model was developed by further analysis including constant comparison and axial coding of the three categories to identify three concepts (Figure 4.4). These are:

- The Intrinsic Influence
- The Professional Effect
- The Human Effect

Figure 4.4 Model 1b: Conceptualising the Relationship within the Physiotherapy Encounter:



In accordance with grounded theory method, these three concepts are defined.

'The Intrinsic Influence' is defined as the intrinsic influence of the organisation, service delivery and the inherent characteristics of the people who deliver and receive that service. It includes characteristics such as the values, attitudes, belief and socialisation felt to be pre-existing in both physiotherapy clinicians and older patients. It also includes continuity of personnel during service delivery and inherent professional and institutional power and hierarchy. This concept has its origin in the Relationship and Clinical Intervention categories.

'The Professional Effect' is defined as the specialist knowledge and clinical skills that the physiotherapy clinician acquires as part of their professional training and brings to the encounter. Such clinical skills may be physiotherapy specific. Their application may be specific to the older patient group. It is informed by the professional codes and boundaries within which the physiotherapy clinician works. This concept has its origin in the Clinical Intervention and Healing categories.

The concept 'The Human Effect' derives from the Healing and Relationship categories and is defined as those personal rather than professional characteristics, including communication skills, empathy, respect and trust that participants felt they brought to the physiotherapy clinician /older patient encounter.

The links between these concepts and the categories develop the model as shown in figure 4.4.

The seven themes previously identified and discussed (4.4.1 – 4.4.7) inform the categories, and hence the concepts, as described below.

The category 'relationship' comprises the themes existence and course, constituents, rationale and value. These themes arise from the data relating to the rationale for and value of the relationship and the various human skills that the physiotherapy clinicians perceive to be important in the development of the relationship – interpersonal skills, engagement and respect. The relationship is seen to be part of the 'human effect' of the encounter between two individuals and an 'intrinsic influence' in the physiotherapy clinician/older patient encounter in that it only exists as a vehicle to administer physiotherapy treatment.

The theme professional power is seen to be an intrinsic influence being apparent as hierarchy in the clinician/patient relationship and as a means of exerting power within the clinical intervention. Thus it straddles the two categories 'intrinsic influence' and 'clinical intervention'.

Other themes within the 'clinical intervention' category include those pre-existing factors that both clinician and older patient bring to the encounter such as attitudes and beliefs and the intrinsic service factors of time, continuity and the environment in which the encounter occurs. As intrinsic factors these are encompassed within the 'intrinsic influence' concept. The frame of reference or professional paradigm within which the physiotherapy clinician works appears to be partly defined by the service and choice of each individual clinician but it is also informed by professional and clinical factors relating to the needs of the patient, the service area and professional experience of the clinician. Thus it sits across the boundary of professional and external factors. Knowledge, clinical skills and professional boundaries are all professional factors that the physiotherapy clinician brings to each patient encounter (intrinsic influence). However, the clinical knowledge and skills are adapted to the needs of each patient through clinical reasoning skills. This is deemed a 'professional effect'. These clinical rather than personal characteristics include physiotherapeutic touch and handling skills. Although these are part of the 'clinical intervention', these factors are considered by the participants to lead to 'healing' and thus sit across these two categories.

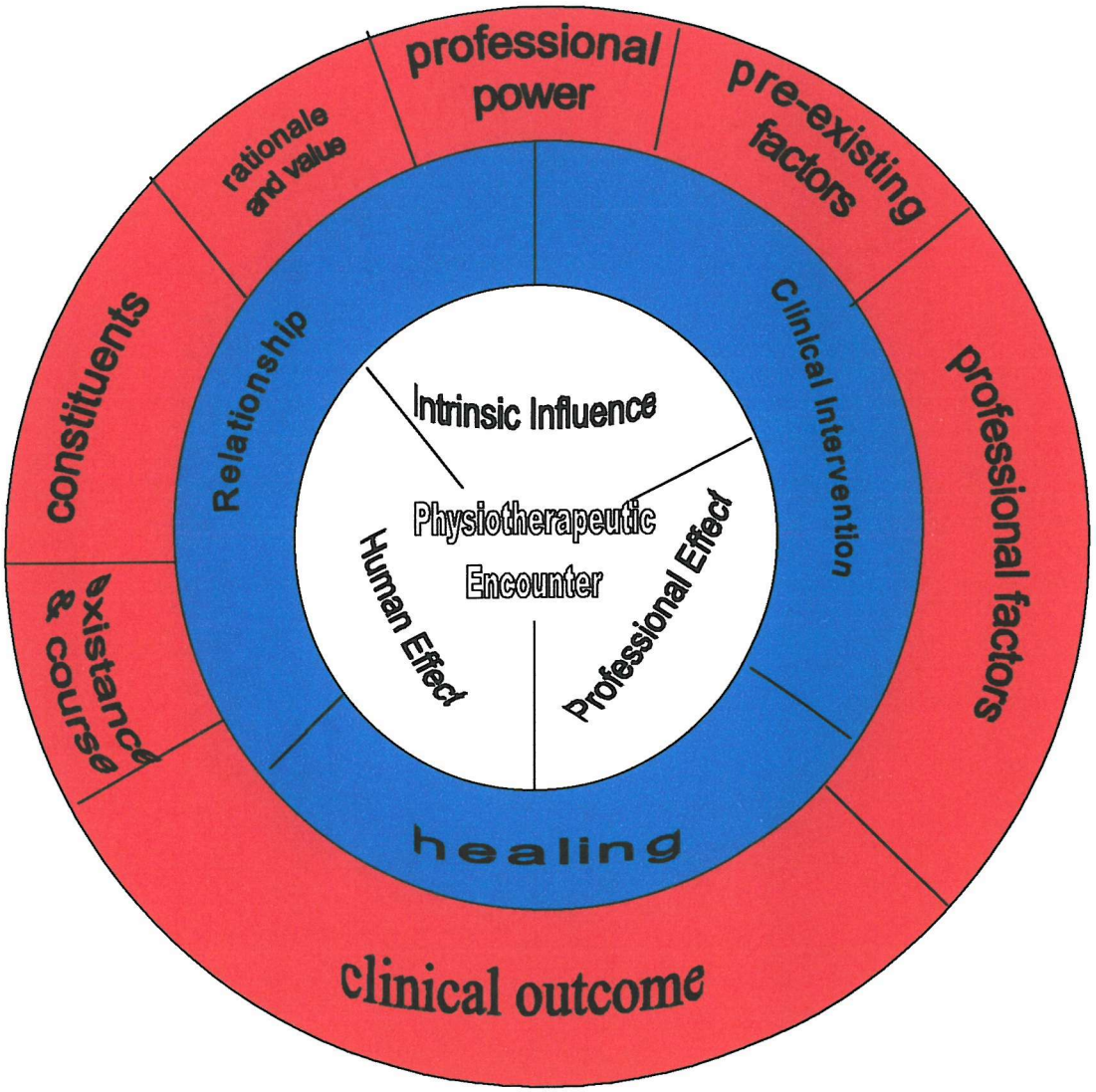
The category 'healing' arises from the theme clinical outcome and relates to clinical outcome, specifically cure, health gain and/or improved quality of life that physiotherapy intervention is deemed to achieve. These outcomes are described as varying according to the patient's pathology and compliance. Cure is the ultimate outcome and can be effected through the 'professional effect' of the skilled qualified physiotherapist. However, compliance with treatment is felt to hasten cure and the relationship is seen to be crucial to encouraging this. Where cure is neither achieved nor achievable, although some health gain may be brought about through the 'professional effect', the role of the human effect' through the relationship in encouraging patients and giving them confidence has increasing import. In many older patients with deteriorating pathology any health gain is likely to be small. Here, although physiotherapy clinicians strive to maximise quality of life through the use of clinical skills, the 'human effect' is more commonly employed. This is illustrated by the withdrawal of specialist qualified physiotherapist skills and the increased use of physiotherapy assistants with highly

developed interpersonal skills to work with patients whose main goal is slow improvement or maintenance of existing function.

Figure 4.5 sets out the categories and concepts in a model describing physiotherapy clinicians' perceptions of the relationship that occurs between them and their older patients. It shows the associations between the relationship, the intervention and outcome and the concepts of intrinsic influences, professional and human effects and the seven sub-categories that inform them.

This study sought to explore the physiotherapy clinician/older person relationship from the perspective of physiotherapists and physiotherapy assistants. Findings suggest that a unique relationship exists between physiotherapy clinicians and their older patients. The relationship develops on two levels, both professional and personal. It exists, from the physiotherapy perspective, to facilitate engagement with assessment and treatment. In doing so it also provides some positive feedback for the physiotherapist or assistant in terms of their feeling of self worth and job satisfaction.

Figure 4.5 Model 2: Physiotherapy clinicians' perceptions of the relationship



4.6 Reflecting on the study

4.6.1 Limitations

The findings of this study are limited by methodological and practical considerations. In pure grounded theory methodology (Strauss and Corbin, 1998a) participants are invited to enter the study as data collection progresses to enable the emerging themes and theory to be explored systematically. Unfortunately, due to service and ethical constraints it was not possible to have free access to the sample and the purposive sample had to be identified prior to data collection. However a wide range of views was obtained from physiotherapy clinicians spanning the full range of professional grades, experience and work places. Only two male participants, one superintendent and one assistant, were accessed reflecting the small number of males working in elderly medicine physiotherapy services nationally. During data collection it became clear that it would be useful to gain the perspective of a physiotherapist and physiotherapy assistant who worked together to get two angles on one specific service. This was arranged but unfortunately did not occur as this particular assistant chose to withdraw from the study. This missing perspective is explored in the final observational study.

The NHS Trust changes in one of the study areas created practical problems of accessing staff during periods of service upheaval. This also explains why the sample population appears top heavy with Senior 1 therapists. This was caused by staff redeployment and rapid promotion of existing staff, some of whom changed grade between selection and data collection.

Grounded theory methodology requires the development and testing of theory arising from the data. Models arose from the physiotherapy clinician study data that are tested in the following two studies. Testing took take place in two ways. The early theory (Models 1a and 1b) was presented to two groups of physiotherapists and physiotherapy assistants working in older person's medicine. These focus groups discussed the relevance and appropriateness of the theory and added new perspectives to ensure data saturation and allowed theory to be developed. Secondly, the older patients' perspectives

study and observational study were informed by, challenged and developed the models and informed the final theory.

Another possible limitation of the study is the researcher's previous employment in the Trusts involved in the research. These geographical areas were chosen to facilitate data collection. It is recognised that some physiotherapy clinician participants had prior knowledge and opinions of the researcher. This was particularly the case in one of the areas where the researcher had held the post of one of the participants some fifteen years earlier. It was considered important to include this participant to complete the sample range and, following data analysis this has proven to be a valid judgement as this participant added important information to the range of views obtained. However, there was definitely some anxiety on the part of some participants to taking part that was founded in this background knowledge. Similarly some participants, mainly physiotherapy assistants, were anxious about taking part in the research possibly perceiving a hierarchy, as the researcher was known to be a lecturer in physiotherapy. They also had concerns about the validity of their views, feeling that as assistants their views were unimportant. The researcher had to be perceptive in acknowledging these anxieties and use sensitive probing interviewing skills to put these participants at ease and assure them of the importance of their opinions and experiences.

4.6.2 Personal Reflection

As a chartered physiotherapist specialising in the treatment of people with neurological conditions in elderly, paediatric and young chronic sick client groups it had become clear to me that clinical outcome was not achieved wholly through natural recovery and clinical skill and I started to consider the characteristics of the physiotherapist/patient encounter. It was apparent that a relationship develops between physiotherapist and patient particularly in clinical situations where disability requires long-term management. Such management could include assisting the patient and their family to make significant changes to lifestyle. The quality of the relationship and the engagement of the patient and physiotherapist certainly seem to improve job satisfaction for the physiotherapist and alleviate some of the anxiety of the patient. Known colloquially and in the more recent

literature as a "therapeutic relationship" an exploration of this from the perspectives of physiotherapists and their older patients became the focus of this research.

This study was conceived and undertaken whilst the researcher was treating two private patients and the experiences of this and past experiences of working as a clinical physiotherapist informed the perspective of this research.

I had been treating one of these patients for many years. This 70 year old woman has a deteriorating neurological condition, the symptoms of which are alleviated by physiotherapy. Such long-term maintenance treatment is not available under the National Health Service. When I started seeing this lady her husband had recently died and she lived alone, her mobility and functional ability deteriorating slowly, compromising her ability to maintain her lifestyle. Over the years she has deteriorated to the point where she is unable to perform any personal activities of daily living and has a full time, live-in carer and friend who provides all nursing and the majority of domestic care. Throughout this time I have treated her once a week in her own home.

This lady has a cheerful disposition despite her considerable disability and has many friends. Quite early on the relationship moved beyond professional and self-disclosure into a friendly relationship. In recent years this relationship has developed into a friendship. Several factors have influenced this. Firstly, she asked me to act as her personal assistant when she went on holiday. The relationship changed from being purely physiotherapeutic to one involving personal care duties of washing and dressing and social activities such as eating out and visiting places of interest. More recently she has experienced several health crises requiring emergency hospitalisation. As she has no immediate family and her carer is a single man, also with no immediate family, my role has shifted again, supporting both her and her carer emotionally and practically during these times. In this respect my relationship has shifted almost to one of surrogate family member and the physiotherapeutic role has become very secondary. Concurrent with this her medical insurance stopped paying for her physiotherapy treatment. Although I still go in every week to do her exercises and massage and advise her carer on pertinent issues

such as safe moving and handling and wheelchair seating this treatment is now on a voluntary basis. The relationship has therefore moved, due to circumstances and tacit agreement from professional physiotherapist/patient to one of surrogate family member undertaking weekly physiotherapy treatment as part of a more holistic relationship and role. Physiotherapists in this study noted that they avoided moving away from a professional/sharing of self relationship as it created problems for goal setting and discharging patients. In this case I made a conscious decision, partly through circumstances, to change my role from physiotherapist to supportive friend/surrogate family member. Had this lady been treated within the NHS she would have received little treatment as there are few goals to be set in such a deteriorating condition and discharge can only occur at death, as there is no possibility of improvement or cure. Her carer would have been expected to add regular physiotherapy exercises to his already busy caring and household duties. Having experienced disability myself in the past I know how beneficial this type of treatment can be, even although it achieves no clinical goals and this undoubtedly became my underpinning philosophy in the treatment of this lady. The relationship between this lady, her carer and myself has been symbiotic. This lady has received weekly treatment that she would not have received though the NHS. She and her carer have received personal support and friendship in times of crisis and I have made two good friends. It would now be impossible to turn back the clock and revert to a purely professional relationship.

Reflecting on this relationship and the physiotherapy clinicians' research informed the relationship I made with the second patient. This is a young man with physical and learning difficulties who I first treated at a special needs school when I was a paediatric physiotherapist working for the NHS and he was seven years old. As he has communication difficulties this relationship has inevitably included his mother. She got in touch with me again through a mutual acquaintance to ask for some advice following an injury sustained by her son, now aged twenty, at college. I started to treat this young man during this study's data collection period.

Working in paediatrics it is common to find parents of children with disabilities who invariably seek more physiotherapy than is available or, sometimes, appropriate in the belief that "more is better". My recollection was that this mother had this belief. I entered this encounter with two main aims around the relationship; firstly to encourage the young man rather than his mother to set the pace and goals and secondly to remain at the "professional/sharing of self" end of the relationship continuum. This was achieved through managing treatment sessions to facilitate obtaining the views of the young man and making weekly goals explicit and writing them down in an accessible format for him. On several occasions the mother tried to draw me into a more friendship relationship and I recognised in myself elements of the anxieties expressed by the community physiotherapists managing patients they had known for many years. As the original goals were achieved, the young man's mother kept finding more problems. This I interpreted as her anxiety that she would be left without any medical support once the episode of care was finished. Once assured that she could contact me should any new problems arise she was happy with the outcome. Maintaining a more professionally led stance assisted with closure of this particular case once the agreed outcome was achieved.

At the time of the physiotherapy clinicians' study it was fifteen years since I had worked in older person's medicine (then geriatrics) and ten years since I had worked in the NHS as a clinician, other than brief locums. Since that time the pattern of service delivery has changed considerably. Patients are no longer treated endlessly but have goals set at their first assessment and are discharged on achievement of these. This, in my opinion, has impacted on the depth of the physiotherapist/patient relationship. Despite the emphasis on partnership it is apparent that the physiotherapy episode of care is still physiotherapist led and physiotherapists tend to remain at the professional relationship end of the relationship continuum to ensure they do not get too involved and compromise discharge.

As the study progressed I started to question the use of the term "therapeutic relationship". Why is this relationship referred to as therapeutic? Certainly the physiotherapy clinician participants felt there were therapeutic elements in both the relationship and the intervention and that elements of both were needed to optimise

achievement of goal, outcome and the satisfaction of both parties. However, no physiotherapy clinician felt the relationship to be therapeutic in the absence of treatment. The three threads - the relationship, the clinical intervention and healing, have formed the basis of the models arising from this study.

4.7 Summary

This study sought to use the principles of grounded theory methodology to explore the perceptions of physiotherapy clinicians of the existence, constituents, rationale for and impact of a therapeutic relationship. A purposive sample of eleven qualified physiotherapists and four physiotherapy assistants working in older persons' medicine was obtained from two geographical areas. Data from interviews, field notes and informal observations was analysed to develop models of physiotherapy clinicians' perspectives on the relationship that they have with their older patients. These are Physiotherapy Clinicians' Levels of Engagement in the Relationship (Fig 4.2), Placing and Conceptualising the Relationship within the Encounter (Figs 4.3 and 4.4) and a Model of Physiotherapy Clinicians' Perceptions of the Relationship (Fig 4.2).

The physiotherapy clinician/older patient encounter is characterised by the intervention and the relationship that grows up between they two parties. The intervention follows a consistent path but the level of engagement in the relationship is dependent on the personal philosophy of the clinician, whether they are qualified and how willing and able the patient is to engage with the clinician. This relationship is perceived to differ from those between physiotherapy clinicians and other client groups only in the rehabilitative nature of the intervention and the past health and illness beliefs and experiences present in older people. Both intervention and relationship are considered to have therapeutic characteristics. Although the relationship is not deemed inherently therapeutic, rehabilitation intervention in the absence of a relationship is considered sterile and unlikely to achieve active compliance, partnership and best outcome. Similarly, a good relationship does not make up for lack of good clinical reasoning and "hands on" treatment skills. The development of a good relationship between physiotherapy

clinicians and their older patients is considered particularly important to diffuse anxieties and promote an equality of partnership that may be a new experience for the older person.

Physiotherapy clinicians differ in the extent to which they engage in the relationship. Qualified physiotherapists are less likely to engage with the patient on a personal level, maintaining a professional stance. They will share elements of themselves both on a social level and to facilitate patient communication in order to define appropriate goals. However, they appreciate the value of a more friendly relationship in encouraging patient engagement with treatment and expect their physiotherapy assistants to do this, gaining further information in the process that is fed back to the physiotherapist to inform goal setting and identify the details required to facilitate discharge. It is not known whether patients actively collude with this strategy.

All the relationships take place within a broader social and cultural dimension. It could be argued that the relationship is therefore both inherently stable, due to the socialisation of both physiotherapy clinician and older patient, yet each relationship has the capacity to be entirely unique, due to the personal components of each party and the way in which the participants relate. It is postulated that small differences within any of these components can affect the relationship and thus the partnership, outcome and ultimate satisfaction for both parties.

Following this study and based on its findings, the term "therapeutic relationship" was reconsidered. The term "therapeutic relationship" as used in the literature appears to relate to the therapeutic environment rather than any inherent capacity of the relationship to effect healing therefore, the term "physiotherapy clinician/older patient relationship" is used in the following chapter whilst the appropriateness of the original term is clarified.

Overall, the clinician/patient relationship literature identifies similar findings to those of this study although literature looking specifically at the physiotherapy clinician /older person relationship is sparse. The particular characteristics of the mode of delivery of physiotherapy to older patients having significant past health care and life experiences

and attending for assessment and management of problems arising from multi-pathology are not currently addressed in the literature.

It could be argued that the physiotherapy clinicians' perspectives models are relevant to all physiotherapist/patient encounters regardless of the age of the patient or type of intervention. In many respects this is possible, however the findings of this study suggest that such models are only applicable to those situations where there is enough time and reason for a relationship to exist. This would preclude one-off physiotherapist/patient encounters and those interventions dealing primarily with the hastening of single impairment cure. Thus these models are probably applicable to medium and longer-term episodes of physiotherapy care where rehabilitation may be complex and require lifestyle changes. Other client groups such as disabled children and young chronic sick clients could also fulfil these criteria. The features that distinguish these models are the inclusion of patient's prior health care and life experiences and beliefs originating many decades in the past. This part of the model is currently only assumed from physiotherapists' perspectives.

Any relationship assumes the participation of more than one party. Thus the perspectives of older people who have just completed a course of physiotherapy are explored in the next study in order to test and, if appropriate develop these models and further explore the role, rationale, constituents and impact of the physiotherapy clinician/older patient relationship. The findings of this study are incorporated in to the interview guides for the following study exploring the perceptions and experiences of older patients to see if similar models arise.

Chapter Five
Older Patients' Perspectives of their Relationship with Physiotherapy Clinicians

5. Introduction

This study was undertaken between March and September 2002.

Eleven individual semi-structured interviews were conducted with older people who had just completed a course of physiotherapy within the Elderly Medicine Departments of the same NHS Trusts from which the physiotherapy clinician sample was recruited for the previous study.

An interview guide was developed (Appendix 5.1) informed by the literature and findings from the pilot and physiotherapy clinicians' studies. As previously, a grounded theory approach was used (Strauss and Corbin, 1998a) and this influenced the participant sampling, data analysis and theory development.

This chapter outlines the aims and objectives of this study, identifies the participant population and sampling processes, data collection and analysis. The findings are illustrated by quotes from the older patients interviewed and models relating to the rationale, role and constituents of their perceptions and experiences of the relationship they developed with their physiotherapy clinicians are presented. A continuum outlining these older patients' levels of engagement with the relationships and how this relates to the physiotherapy clinician's continuum is also presented and discussed. This chapter concludes with a section reflecting on the researcher's experiences, the particular limitations of this study and a summary.

5.1 Aims and Objectives

The aims and objectives were similar to those explored with the physiotherapy clinicians.

Aims:

To explore the views of older people who have recently completed a course of physiotherapy within an Elderly Medicine Rehabilitation Service with regard to:

1. Whether a relationship exists between them and their physiotherapy clinicians.
2. Whether such a relationship could be deemed therapeutic.
3. The rationale for such a relationship.
4. What such a relationship comprises.
5. The course of the relationship.
6. The factors that impinge on such a relationship.

Objectives:

1. To gain insight into the views, perceptions and experiences of these older people with regard to the above aims through individual semi-structured interviews.
2. To use the data collected early in this study to inform the theoretical sampling and interview schedules in later interviews in order to ensure a breadth and depth of participant views and to test and develop the emerging models.
3. To compare and contrast the findings of the two studies (physiotherapy clinicians' and older persons' data) together with relevant literature to further develop models of the physiotherapy clinician/older patient relationship.
4. To inform theory development through a grounded theory approach to data analysis.
5. To reflect on personal beliefs and experiences and explore how these impact on data analysis and interpretation.
6. To use these findings to identify further topics to explore with the final case studies

5.2 Participant Population and Sampling

Approval from local ethics committees and NHS service managers was obtained to gather data in the four Portsmouth and Chichester NHS Trusts that provide elderly medicine rehabilitation services. Ethical approval was obtained to interview eight

older patients from the Portsmouth NHS Trusts and four from Chichester. This original sample size was based on those used by other grounded theory studies exploring patient perceptions (6 –27 patient participants), (Phillips and Woodward, 1999; Teram et al, 1999; Cook and Hassenkamp, 2000; Bäckström and Dahlgren, 2000; Stephenson and Wiles, 2000.) Grounded theory methodology requires that purposive and theoretical sampling is continued until data saturation is achieved (Strauss and Corbin, 1998a: 203). Therefore access to a sample of this size was requested from the ethics committees with an option to return for further permission should further data saturation be required.

The sample was chosen from a population of patients being treated at the same four Trusts from which the physiotherapy clinicians' sample was drawn. This was to ensure that any identified service provisions were comparable. This study was undertaken a year after the substantial health service changes alongside which data was collected from the physiotherapy clinicians. The four Trusts provide acute, day hospital and community elderly medicine rehabilitation services and have dedicated physiotherapy services for older people.

Inclusion Criteria:

The older people approached to participate fulfilled the following criteria:

- 65 years and over, i.e. the age at which patients requiring rehabilitation are managed by Elderly Medicine Services within these NHS Trusts
- Able to give informed consent to participate in an interview lasting up to one hour i.e. no cognitive or learning impairment, no confusion or dementia, medically well enough to consent and participate, able to communicate adequately in English.
- Completed a course of physiotherapy in the elderly medicine rehabilitation service in one of four Portsmouth and Chichester NHS Trusts within the previous two weeks. The course of physiotherapy comprised a minimum of one physiotherapy assessment plus two treatment sessions as physiotherapy clinicians felt that a relationship could be established with an older patient during this time. Treatment sessions could have been conducted by a physiotherapist or physiotherapy assistant / technical assistant.

Preferred Inclusion Criteria

- Patients having completed this episode of care entirely within Elderly Medicine Services of these Trusts (i.e. not transferred from medical wards or another Trust etc) to ensure some continuity of personnel.
- Have received day hospital, community or domiciliary physiotherapy rather than inpatient, unless followed by non-inpatient physiotherapy.

An initial purposive sample of people fulfilling the inclusion criteria was sought to ensure a wide range of views from older people (Appendix 5.2). This was developed to ensure a wide range of views and experiences and included gender, age, home address and type of accommodation, length of physiotherapy episode of care, past experience of physiotherapy, reason for referral to physiotherapy. The first six people interviewed in this study fulfilled the purposive sampling criteria representing a range of ages (67-91 years), male and female, presenting clinical conditions, all retired from professional, blue collar and unskilled work and living in a range of environments including city centre residential care to living with spouse or alone in owner occupied accommodation in the countryside. In addition their lengths of physiotherapy care and relationship with their physiotherapy clinician ranged from 3 weeks to 18 months. As these data were collected and analysed it was possible to use the emerging findings to inform a theoretical sample that sought participants describing particular relationship experiences with their physiotherapy clinician. These included participants who described their relationship as absent or poor, technical or professional, distant or friendly, a partnership, coercive or dependent. These characteristics were determined initially through the perceptions of the gate-keeping clinicians and later at the initial introduction to the patient.

5.3 Data Collection

Data was collected between February and September 2002.

Physiotherapists working in the NHS Trusts identified possible participants towards the end of their episode of care and contacted the researcher who decided whether the patients fulfilled the inclusion criteria and, later, the theoretical sampling requirements. The treating physiotherapist then discussed the project with the patient. Those expressing interest were then introduced to the researcher by the treating

physiotherapist. If after explanation the patient was still interested, they were left with an information letter and given seven to ten days to consider their inclusion in the study. The researcher then phoned them at an agreed time to arrange an interview.

A single interview was conducted with each consenting participant in their own home within two weeks of the end of their physiotherapy treatment.

The initial interview guide (appendix 5.1) addressed the aims of the study and developed within and between the interviews according to the patients' responses and themes arising in line with grounded theory methodology (Strauss and Corbin, 1998a). Fewer changes were made to this interview guide than were made to the earlier physiotherapy clinician's guide. The only new themes arising were those of dependency and closure. These arose early in the study and were explored in subsequent interviews.

5.4 Data Analysis

Data transcription and analysis was undertaken in the same way as for the physiotherapy clinicians' study. Transcribed interviews were entered into qsr NUD*IST software package for coding and in-depth analysis. Initial analysis of the early interviews informed subsequent theoretical sampling. Field notes and memos were also recorded and used to inform category and concept development using the principles of grounded theory methodology (Strauss and Corbin 1998a).

5.5 Participants

Interviews were undertaken with eleven older people who had just completed a course of physiotherapy. Their demographic data is set out below to describe the sample informing the findings.

Eight older people were recruited from the Portsmouth area and three from Chichester. In total twenty-one patients were considered of which three declined to participate or did not fulfil the theoretical sampling criteria, one was too young to fulfil the inclusion criteria, one was found to be too confused to participate, four were withdrawn when their health deteriorated and one died. Of the participants recruited

eight were female and three male. Their ages ranged from 67 – 91 years. Table 5.1 sets out the characteristics of the participants.

Table 5.1 Characteristics of older participants (in order of age)

Gender	Age	Marital status	Physiotherapy services accessed (length of EOC)	Previous occupation	Accommodation
Male	67	Married, lived with wife	Inpatient/ Outpatient/CRT (10 weeks)	Trades union official	Flat, (Local authority)
Female	67	Divorced, lived alone	Inpatient/Day Hospital (9 weeks)	Clerical officer	Mobile home (owner occupier)
Female	70	Widowed, lived alone	Inpatient/CRT (3 weeks)	Wages supervisor	Flat (Sheltered accommodation)
Female	73	Widowed, lived with son	Inpatient/CRT (7 weeks)	School meals supervisor	Bungalow (owner occupier)
Female	78	Widowed, residential care	Inpatient/Day Hospital (18 months)	Enrolled nurse	Residential care
Male	78	Married, lived with wife	Inpatient/Day Hospital (10 weeks)	Blue collar worker	Mobile home (owner occupier)
Male	82	Married, lived with wife	CRT (5 months)	Accountant	House (owner occupier)
Female	89	Widowed, lived alone	Day Hospital (4 weeks)	Primary school teacher	House (owner occupier)
Female	85	Married, lived with husband	Inpatient/Day Hospital (6 weeks)	Unknown	House (owner occupier)
Female	90	Widowed, residential care	Inpatient/CRT (5 weeks)	Domestic help	Residential care
Female	91	Single, lived alone	Day Hospital (5 months)	Children's nanny	Flat (owner occupier)

CRT – domiciliary physiotherapy through community rehabilitation/enablement team

EOC – episode of care

5.6 Older patients' perceptions and experiences of the relationship

Analysed findings from the older patients identified almost identical themes to those found in the previous study although some were informed by different perspectives.

Five themes emerged strongly. These were:

- Existence and course of the relationship
- Constituents of the relationship
- Professional power and hierarchy
- Pre-existing factors
- Impact on outcome

The themes rationale and value of the relationship and professional factors were also present but to a lesser degree than in the previous study. A discussion of the emergence of themes in the physiotherapy clinicians and older patients' studies and the potential for manipulation of data into predefined themes is included later in this chapter.

Identical categories and concepts were also identified. The concepts of Intrinsic Influence, Professional Effect and Human Effect were clearly present in the older persons' experiences. These related to the categories Clinical Intervention, Relationship and Healing in the same way as in the physiotherapy clinicians' study. Unsurprisingly, most new topics arose in the codes and themes relating to patient and physiotherapist characteristics and the role of the patient in the relationship. A new, unexpected code relating to patients' experiences and perceptions of closure of the relationship and the ending of the episode of care also developed as did a separate theme relating to inherent professional hierarchy within the power coding leading to a change in the theme name (professional power and hierarchy). The theme 'impact on outcome' developed from that identified by the physiotherapy clinicians to encompass the older patients' broader concept of the outcome of their experience that included their illness/disability as well as the physiotherapy encounter. Other new codes arising from the older patients' data included factual information about the type of physiotherapy intervention experienced and patient demographic data relating to lifestyle and occupation (see Table 5.1).

All these themes are now considered and illustrated with quotes from the older patients. Each quote is referenced using the participant code OP1-11 (Older patient code numbered one to eleven) and qsr NUD*IST text units.

5.6.1 Existence and course of the relationship

The majority of participants agreed that a relationship had developed between themselves and their physiotherapy clinicians. Close links between the clinical intervention, the human characteristics of both parties and recovery and healing were again apparent.

"Immediately she worked with me there was, I can only put it as a sort of bonding in as much as I felt so confident and felt that umm... I don't know quite how to explain it... that umm, I just felt very, very calm and confident with them." (OP2: 211-214)

Older patients' perception of the process of the physiotherapeutic encounter is similar to that of the physiotherapy clinicians in that they describe the relationship occurring alongside and because of the clinical intervention. All described the link between the process of the episode of physiotherapy care and the relationships they had with their physiotherapy clinician(s). Figure 5.2 is a synopsis of their experiences.

Eight of the (eleven) older patients interviewed in this study had experienced physiotherapy rehabilitation in at least two venues during this episode of care. Many had been inpatients in acute or intermediate care or social rehabilitation units prior to further rehabilitation in day hospital or domiciliary settings. Few had clear recollections of any physiotherapy intervention in acute inpatient settings supporting the earlier decision not to include those patients receiving only inpatient physiotherapy in this research. Most participants were only able to describe fully those relationships with the physiotherapy clinicians who treated them in the last venue where they undertook their treatment. Even where treatment in earlier venues was poorly recalled, older patients were still able to remember different physiotherapy clinicians in different venues during a single episode of care. Therefore, the older person's experience of the physiotherapy clinician/older patient relationship could be different to that of the clinician who sees their discrete intervention as a complete entity (Figures 4.1 and 5.2).

Figure 5.1 The physiotherapy episode of care, older patients' perspective of the clinical intervention and attendant relationships

Clinical intervention				
Trauma or illness	**Intervention**			
Referral to health services	Venue 1: Initial contact	Venue 1: Assessment, Treatment, Onward referral	Venue 2: Assessment, Treatment, Review	Discharge
Older patient/physiotherapy clinician relationship				
Prior knowledge of physiotherapy	Venue 1 May or may not be aware that physiotherapy has been prescribed	Getting to know physiotherapy clinicians, the structure and processes of the service	Get to know clinicians and service delivery at new venue	Coping with closure

Whilst physiotherapy clinicians have prior knowledge of the patient through a referral letter or medical notes some patients did not even know that they had been prescribed physiotherapy and expressed surprise when the physiotherapist arrived to assess and treat them. However, this did not appear to affect this patient's compliance.

"No he [the doctor] didn't tell me [I was going to see the physiotherapist]. No I didn't know, not until she came in and introduced herself. But I did what I was told and that's that." (OP1: 93-97)

Some people had experienced physiotherapy treatment before and those who had not still had some idea what it would involve.

"[I didn't know]... not an awful lot, but I did know a bit. The person that I worked for, her daughter was a physiotherapist and I'd heard little bits." (OP3: 44-47)

Lack of prior knowledge did not seem to impact on the relationship once the initial anxiety about the unknown was eased.

"I think most people have some sort of fear - well I did. I said "I'm a new girl", I just don't know quite how to go on. Err... and they were very kind." (OP10: 59-61)

"I'd never had it [physiotherapy] before. No, I didn't know what was in front ... well, I had an idea, you know with the name, but I haven't experienced it before. First time for everything isn't it. Even at 91!" (OP1: 74-78)

Closure of the relationship alongside the episode of care was something that physiotherapy clinicians did not consider in any depth. Although they displayed some reluctance to stop treatment without further support i.e. offering telephone support or review appointments, they did not display the sense of loss exhibited by some older patients interviewed for this study. The older patients expressed a range of views concerning closure. All saw closure as inevitable. Some viewed it dispassionately having no emotional component.

"I: So how do you feel now that that... now that J's [the physiotherapist] not coming to see you anymore?
P: Well, I don't know that I feel a lot, nothing at all really. I know that she's done as much as she possibly could for me and she's encouraged me and told me to keep on doing certain things." (OP7: 293-300)

Some felt that closure was out of their control, respecting the professional opinion of the physiotherapy clinician to end the episode whilst identifying the benefit of the treatment and relationship.

"Err yes, because I think she's done... she solved my problems. You can't cure arthritis and umm... the exercises should help. And the main thing is umm... confidence to go out and join the world again." (OP10: 308-310)

For most, discharge from treatment was a bittersweet occurrence confirming that maximum progress had been made whilst necessarily ending the contact.

"When she said "I don't want to see you again" umm... basically you think "Good, I'm getting there" you know, I haven't got to come back again. But at the same time you do feel a bit sad that you're not going to see them on a regular basis, you know. (OP4: 409-414)

Patients were keen to show that they realised that they were "one of many" and could not expect the physiotherapy clinician to reciprocate their feelings at the end of the episode whilst hoping that the relationship had indeed meant something to them.

"... I mean, with their lives they must meet so many people they cannot afford to get... carry on a relationship after they've dealt with them. That I can appreciate. But I'm sure that she'll sort of always... probably remember me and I shall always remember her." (OP2: 561-564)

"I do miss 'em very much but there again you can't hang onto these people all the time can you. When they've done their job they've done their job, ain't they." (OP3: 384-386)

Patients appreciated positive feedback from their physiotherapy clinician about their treatment and how they were getting on. The older patients felt that, in the main, they worked hard at their exercise programmes and although there was no evidence that they sought accolade, they all gained pleasure from acknowledgement of this, both as recognition of physical improvement and because all wanted to please their physiotherapy clinician and be thought well of. Although physiotherapy clinicians were conscious of actively using this practice as a teaching technique to reinforce correct movement behaviour and encourage compliance, they showed little appreciation of the impact such praise had on the frame of mind of the older patient and the subsequent impact on the relationship. It may be that by using positive feedback to encourage patients, physiotherapy clinicians are unwittingly encouraging dependence not only as the gate keepers to physical recovery but also through being perhaps the only people to provide the older disabled person with a sense of achievement and self worth. Ending treatment therefore, for many older people, especially those living alone or having to adjust to sudden onset disability, would not only seem to end the hope of further physical recovery but also remove the positive reinforcement of self worth that the rehabilitation techniques encourage. It is not surprising that discharge from rehabilitation was so upsetting for some of these older patients.

The older patients described the majority of relationships in glowing terms.

"...a very, very nice and very, very helpful person - I though she was anyway, you know so... And from what I could see of the other physios they were just the same." (OP4: 73-75)

"Yes, yes. The greeting, the smile, you know and the concern, immediately. They cared." (OP2: 329)

Not all relationships had been so good. Two participants related experiences with physiotherapists that they felt had been poor. Interestingly, none of these experiences had occurred in the physiotherapy services taking part in this study. Both participants felt that the actual treatment had been appropriate although both felt that their relationships with the physiotherapy clinicians had been compromised.

"I don't know, she knew her job, I wouldn't say she didn't know her job, but I just felt that she didn't have that little bit of umm... encouragement, technique that the other one had." (OP9: 171-175)

In one case, a very strictly prescribed service delivery was also felt to have affected the relationship.

"They were very good, very good. They umm... I can only say they were very good. They were very strict. You had to ... there was no shirking... [but] I felt that I could not get close to them, in particular, one particular therapist that, she worked very hard with me..., I would like to have known a awful lot about her but I never got that close enough to her. You know, the barriers went up." (OP2: 32, 114-115, 119-120)

As previously identified with the physiotherapy clinicians, older patients recognised different levels of engagement within the relationship. Most described an initial uncertainty or anxiety relating to their knowledge and expectations of the encounter followed by the adoption of a level of engagement that sat on a continuum between no apparent engagement and a dependent relationship (Figure 5.2).

Figure 5.2 Older Patients' Level of Engagement with the Physiotherapy Clinician/Older Patient Relationship

No engagement with relationship	Obedience	Sharing of self	Friendly relationship	Friendship	Dependent friendship	Dependency

Not all participants reported that a relationship had occurred between themselves and their physiotherapy clinicians. One person could not recall having received physiotherapy treatment in a social rehabilitation unit. She recalled seeing the physiotherapist at home but spoke about her in a detached way and showed no evidence of having formed any type of rapport or relationship. The other participant, whilst being very alert and describing a positive rehabilitation experience, was unable to distinguish between different health care professionals and recalled no-one's name other than the doctors, even although the episode of care had ended only days previously. This woman presented as very self sufficient and self absorbed and showed no evidence of having related to the physiotherapists on a human level.

"Oh no I'm afraid I don't [remember the name of the physiotherapist]. I think the same two people came most times, yes, I'm sure they did." (OP11: 99-100)

One of these participants described a very obedient response to the physiotherapist. Here the relationship showed no evidence of partnership, rather an acceptance of clinical authority. Engagement with physiotherapy rather than with the physiotherapy clinician in this case was driven by the patient's perception of their status within the situation including their perception of professional hierarchy. Blind obedience may also occur in other situations, for example where the patient is too ill to proffer any personal engagement or is socialised to this behaviour. The quotes below are from a participant who had been in domestic service all her life and had no experience of being asked for her opinions.

"She [physiotherapist] just told me what to do and I followed her, you know. I did what she told me to. ...well, I believe in going to see people like that and doing what you're told because it's all done for a purpose." (OP1: 60-66)

"I was always like that. I know I'm 91 now but from a child I always did what I was asked. I don't ever remember saying no to anybody. Well I was brought up to do as I was told indoors so I did the same outdoors." (OP1: 306-309)

Several participants demonstrated different levels of sharing of self within the relationship. One patient remained quite aloof within the relationship remaining within the professional bounds of the encounter whilst acknowledging that there was a human element to the encounter and sharing only that personal information necessary for the physiotherapy clinician to direct rehabilitation.

"Not too personal, you don't want to strike up a relationship but enough to be... to treat you as a human being rather than just a piece of... rather than just the next object to be treated, if you follow what I mean." (OP7: 143-146)

"[We talked about]... well, relationships with family, where they were, you know. Had I got any difficulties, shopping or anything like that." (OP10: 194-196)

Some participants described sharing more personal information expanding on that required simply for rehabilitation. Sharing this kind of information enabled the patient to present themselves as a more rounded human being rather than just a patient with health care needs.

"Yeah, we talked about going on holiday and our son who works in the health service over in Majorca, you know." (OP9: 412-413)

Some participants described seeking some sharing of self from the physiotherapy clinician. Here the patient seeks reciprocal personal information from the physiotherapy clinician beyond the strict bounds of the rehabilitation setting. However, this exchange remains on a factual rather than intimate level although it does allow the patient to see the physiotherapy clinician on a human as well as a professional level and may contribute to how comfortable the patient feels with the clinician and the encounter as a whole.

"Well, [we talked about] more or less things that were going on and she was telling me ... I think it was her thirty something wedding anniversary." (OP8: 78-79)

"Oh yes, yes. Talked about her children and, umm, she did take me, the first time we went for a walk she said "I think we'll go for a walk today" and we went down to the Post Office and, umm, we were talking about just ordinary things, everyday things." (OP4: 133-136)

Such a relationship was described by participants as friendly. In this relationship, personal chitchat is reciprocated. The older patient starts to feel they can confide anxieties in a human rather than a purely clinical way. Close friendship (a reciprocated relationship) is withheld by both parties, as the patient is very aware of the professional and time boundaries to the episode of care. Participants differed in their definitions of friendly and friendship. Several participants described their relationship as friendship, but on further questioning admitted that they could not call their physiotherapy clinician a friend such as they may have within their own circle of social acquaintances.

"I don't think it was quite as deep as friendship but it was more than, if you like, patient come physio sort of thing. From the first time I saw her she just put you at ease. She was there to help you." (OP4: 293-295)

One participant, however, did consider her physiotherapy clinician to have become a friend. This was described as a reciprocal relationship where personal and professional information, experiences and anxieties were shared. This patient still appreciated the professional and time boundaries but hoped the relationship would remain on a different basis after the episode of care ended. In this instance the relationship had indeed ended at the closure of the episode of care.

"That's finished with the treatment. Yes. No, I did say to her... we both said "We hope we meet again" and I would dearly love to see her again. But umm, I know she lives at [place name], I know she's got dogs, I know the dogs' names and I know what sort of life she leads and I just hope that I bump into her one of these days." (OP2: 556-560)

Whilst it appeared that some patients had come to depend on the physiotherapy encounter in that it provided hope for their continuing rehabilitation as well as an outing, for several older patients the end of the episode signalled the end of the relationship that they perceived was at least as important as the treatment. Two participants cried openly during the interview when reflecting on the closure.

Two older patients appeared to have developed a degree of physical or emotional dependency on their physiotherapy clinician that still impacted upon them after the episode of care had ended. In this scenario one patient rated the relationship as more important than the treatment, fearing the end of the episode of care as it meant the loss of the relationship. Both these participants were women who had suffered strokes that had profound and sudden effects on their independence and mobility. One lived alone and the other had moved into sheltered accommodation, as she could no longer manage independently in her own home. It is possible that these circumstances could have contributed to this dependency. These participants appeared, due to loss and circumstances, to have invested all their relationship "eggs" in this encounter "basket".

"I really enjoyed being with them. I miss them something terrible now. I think this is what you miss." (OP3: 206-207)

Certainly those older participants living with a spouse or other family members and those having experienced less profound sudden onset disabilities did not display the same dependency. However, it is not appropriate to make generalisations from a small sample. These lone older patients appreciated a supported discharge from treatment as a gradual means of withdrawing from both physical and emotional support. In others, the social elements of the treatment venue and relationship with other health care professionals and older patients were an important factor.

"She said "All you've got to do is ring up and there's someone here to talk to you". I think that is a big help actually and I think perhaps as people live a way from other people they haven't got many people round them you can feel a bit lost when you first come home." (OP4: 416-418)

"And they really are great there [Day Hospital]. ... and if you ask them anything, you know, they are so willing and so kind. And to me it's got a tremendous atmosphere and character to the place." (OP5: 353-356)

5.6.2 Constituents of the relationship

Older patients described the constituents of the relationship they had with their physiotherapy clinicians. In the main these matched those identified by the physiotherapy clinicians including good interpersonal skills, interaction and respect. However, most of the older patients did not highlight any negotiation skills or goal setting. They were more likely to see this as the professional role of the physiotherapist and to be led by them.

Older patients described interpersonal skills of the physiotherapy clinicians and themselves that they felt contributed towards the relationship. These were in addition to their intrinsic attributes such as personality and past experience and included communication skills, empathy and caring.

The physiotherapy clinicians' ability to listen and explain was seen to be crucial to putting the patient at their ease at the start of the episode of care, gather appropriate information to direct treatment and appreciate anxieties when approaching discharge.

"Yes, and I think they listened and they understood what each patient individually needed. I mean my physiotherapist knew when I'd talked to her a bit that I needed to get my balance and get my confidence to go out of the house." (OP10: 97-100)

Older patients also identified their responsibility to reciprocate in order to facilitate engagement within the encounter.

"I mean, how can they do their job if you don't tell them how you really feel, you see." (OP11: 313)

Older patients felt more comfortable in the encounter when physiotherapy clinicians empathised with their accounts and feelings. They appreciated seeing the human as well as the professional side of the clinician.

"It might sound strange but I mean, it shows that they have the human touch. It's ... they are human the same as us. The same as the patient and therefore you then give yourself more to them." (OP2: 443-446)

Similarly, a caring attitude was felt to enhance the relationship. In particular older patients felt valued and included where the physiotherapy clinician showed a genuine interest in them. A caring approach encouraged the older patients to work hard to please the clinician.

"Well, she seemed to know exactly what she was doing, rather than just giving a treatment and she seemed to take an interest in me as a person and what I was aiming to do, which was to get better really." (OP7: 74-80)

"Yes, I think there is a certain amount in that because I think you can..., well, you know I must try because she's interested in me, and she'll be, you know, hoping that I'll do a bit more each time." (OP7: 259-261)

However, older patients felt that they could see through a patronising approach.

"I had several different physios and I could sense the ones err who were genuine err, who really wanted to help me get better. I'm not one of these that takes to flattery too much so I can sense it pretty well whether it's genuine or not (laughs). They've got to be genuine. It can't just be an act" (OP9: 596-599)

Humour had a role in diffusing and lightening difficult situations and in correcting without demeaning.

"Well, there was one situation once where [the physiotherapist] said to walk along catching hold of the bars and err I stood up like this without holding and she said "Now catch hold of the bars we don't want blood around here!" You know (Laughs) but you were being told off but in such a nice way, you know." (OP6: 285-289)

"... we used to have some laughs. Cos sometimes if you didn't laugh you'd be crying the whole time, you know it um.... But no, very, very nice..." (OP4: 71-73)

However, patients identified boundaries, feeling that humour could be inappropriate if it became too personal or transgressed confines of good taste or normal social behaviour.

"Well, [humour is important but] only so far. Not to get to be sort of saucy - but they would never be that, would they." (OP11: 463-464)

Encouragement was attributed to physiotherapy clinicians who used it to build confidence, enliven and reward success.

"Now all through this treatment she has been very professional and very helpful and I've found her very, very encouraging because as you know, otherwise you could sit down and moulder away." (OP7: 30-33)

"Yes, yeah and they sort of encouraged me to walk. But she was... they were very encouraging. [The physiotherapist] was particularly. She was.... and I always felt confident when she were there cos she was one of those people... she put a bit of confidence into you. And you thought you could do it because she said you could, you know." (OP3: 78-86)

Inspiring and instilling confidence was seen as a major factor in the clinician's role in the relationship having the ability to change the older patient's perception of their self and ability from negative and helpless to positive and proactive.

"She gave me just what I needed, a sense of confidence and balance so that I could look after myself. I said "Right I can look after myself", she said I could so I thought [the physiotherapist] said I could, so I will!" (OP10: 236-238)

However, older patients felt that any confidence built was very fragile and could be shattered with a single ill-advised comment. Some participants demonstrated low

self-esteem, believing that they may deserve some criticism and commending clinicians for having patience with them.

"I think that is one of the most important things. I think to give people their self confidence. You know, they've only got to say something "Oh look at that" then you've lost it, you know. ...she said "Oh what are you like, what good's that" you know. You come back and you think "Oh God, I've done that all wrong today" and it's very easy to upset and depress somebody when they're in that state. If somebody said to me "Oh that weren't no good, what you done there" that really... I've lost it then you see." (OP3: 333-344)

" I think that umm... they've got to have a lot of patience with people and this did come over. She had an awful lot of patience." (OP4:89-91)

Whilst the physiotherapy clinicians felt that both parties contributed to an interaction within the encounter, the older patients did not perceive this to be partnership in the same way as the physiotherapy clinicians. They described engaging with treatment and the relationship in order to please them, feeling a need to be liked on a human level and taken seriously as a patient.

"I mean, you want them to know you're doing it. You want to impress them and you want to know... you want to hear them say "Well that's five degrees more than it was yesterday. Well you're our star patient", you know." (OP9: 575-581)

"Well, I think giving back [to the physiotherapy clinician/ older patient relationship] is the progress you make, when they say to do this, you're taking it and the progress you make you're giving it back to them. They're not making umm... kind of rules and things like that but they're giving you their experience to get you better and, oh yes, it's a big thing I think." (OP6: 234-239)

Very few older patients felt that they had been involved in goal setting or partnership in their care. In the main they expected the clinician to take the lead role in deciding what outcome should appropriately be aimed for. This arose from a belief that the

clinician had the professional knowledge and status to make this decision. Many did not seek a proactive role in partnership.

"She [the physiotherapist] just told me what to do and I followed her, you know. I did what she told me to. I could [have had a say in the direction the treatment took] but they know their job and I'm here to do what I'm told so I just follow what they ask me to do." (OP1: 60-61, 296-297)

Only one patient described taking a more active role in his treatment decisions and progress. He was one of the younger participants who had received physiotherapy over many years. He had recently retired as a trades union official and was used to negotiating in a working situation. These experiences undoubtedly influenced his response to the encounter. The quote below illustrates his views of the importance of the partnership between trust in the physiotherapy clinician and the clinicians' belief in the patient. He sees this partnership in the relationship as a precursor to partnership in the treatment.

"With some of them, yes [I had an equal partnership]. I think with some of them I... I felt that... they wanted me to get better and they knew that they could help me to get better. Yes, I'd put my trust in somebody like that. They believed in me... it's like a two-way thing. For them to do their job well, you've got to do your job well. And if you don't get that attitude where you're both singing from the same hymn sheet, you might as well go home, you know." (OP9: 270-276)

Some older people would have liked an element of choice and partnership in the encounter but were reluctant to challenge the clinician's decisions and expertise in case it jeopardised the way they were perceived by the health care professionals.

"Well I suppose you could have said no but the thing was, my aim was to get well and get out and get back to England. But by the same token I appreciated that this was necessary to get fit." (OP2: 58-60)

Mutual respect was seen as a key component of the relationship. The older patients expected to respect their physiotherapy clinicians as knowledgeable, skilled people

having the authority to determine their rehabilitation. In some cases older patients described the physiotherapy clinicians' role as extending to include acting as a mediator between patient and doctor in vital decisions such as discharge date and even whether they could actually return home. Although initially patients automatically afforded the physiotherapy clinician respect by virtue of his/her status and role, continuing respect had to be earned through their approach and treatment during the episode of care. Past experiences of health care gave some older patients expectations that this respect may not be reciprocated and they expressed satisfaction when they felt attitudes had changed.

"I think these days the physiotherapy and nurses in general treat you more as a person rather than an object sort of thing. You know, they treat you more as a human being these days than as just an extra thing to be done, sort of." (OP7:128-131)

Respect was enhanced as the older patient came to trust the physiotherapy clinician. Some patients automatically trusted them purely by virtue of his/her professional title and the perception that they had of the medical profession and their role to be unquestioningly obedient.

"If I'm under medical observation I always do what I'm told because I think meself "That's what you're here for, different people like". Like [if] the doctor asked me to do anything I'd do it. I don't argue with anything. I do what I'm told." (OP1:84-87)

Other patients developed trust through their response to the physiotherapy clinician's demeanour and professional skills. Many patients felt that the physiotherapy clinician needed to share something of themselves in order for them to feel comfortable enough with them to trust them fully with their physical and functional problems. They were quick to make links between a trusting relationship and compliance.

"You just felt that being with her, you could just trust her. She knew what she was doing and if you wanted any help or you weren't happy with the way things were feeling in your body you could talk to her about it." (OP4: 153-156)

"I know enough about her [the physiotherapist] to know that she's somebody I trust. That's very important, yes. Because if I didn't trust somebody you'd get nowhere with me." (OP5: 151-155)

5.6.3 Rationale and value

Patients described the relationship on a personal and professional level as a means of engendering trust and facilitating communication and confidence in their physiotherapist and the treatment.

"[the physiotherapist] was ready to listen and then give me hope and help." (OP10: 223-224)

The relationship was seen to have value by all older patients. Where relationships were not present or described as poor the whole encounter was perceived as inadequate.

"I did feel that they just didn't want to be bothered." (OP9: 129-130)

However, where relationships were good, the encounter was memorable and deemed a positive experience even if the clinical outcome was poor. This quote comes from a woman who, following a devastating stroke with limited physical recovery following many months of physiotherapy was unable to return to her own home or independent living.

"I think they were marvellous, meself. If I had to vote for them, I'd put up two hands! Yes, yes they were good." (OP: 89-91)

5.6.4 Power and Hierarchy

Whilst the physiotherapy clinicians were very conscious of the power relationship within the clinician/patient dyad the older patients were more likely to interpret this as an inevitable and necessary professional hierarchy. All older participants bar one, a retired male accountant, felt that a hierarchy existed between themselves and their physiotherapy clinicians. Most had experienced a more formal and overtly hierarchical health service in the past and expressed surprise that it had changed so

much. Although most preferred the more relaxed approach, one older person felt that some discipline was necessary to retain the clinician/patient role. However, all participants wanted to be treated as a human being and included in the encounter even if only as a passive recipient of treatment. No one wanted to be "talked over" as this was felt to show a lack of respect.

"Well I think it's much more friendly and umm... not so awe-inspiring, you know. I mean people used to tell me Matron used to see that all the sheets were just so. It was like the Queen coming round, you know. But now it's informal. They seem to think of the patient and feeling comfortable and at ease." (OP10: 52-57)

"You see the doctors were more or less the rich people. Very often they'd inherited the practice from their father and grandfather, you know. They weren't unfriendly, family doctors, but it was really the expense of going to the doctor that prevented a lot of people calling when they should have done. The doctor was the aristocrat." (OP10: 265-274)

One day-hospital doctor in particular was felt to have broken the taboos of clinician/patient hierarchy by portering patients within the clinic. This participant felt that this was one factor that contributed to her thinking of this doctor as a friend although she knew no personal information about her.

"There's [Dr P] and she's the sweetest person you could possibly want. She is absolutely marvellous. And I'll tell you why. Not only when she's seeing you and that but she will push you out of her office, and she'll push you round and she'll take you round or she'll pick people up and she'll take them. She's not a doctor on a pedestal. She's an absolute marvel." (OP5: 275-282)

Another participant felt that the friendly relationship that developed between her and her physiotherapy clinician equalled out her initial perception of hierarchy.

Most participants wanted there to be a hierarchy between themselves and their physiotherapy clinician. They felt that the relationship was friendly, not pushy and physiotherapy clinicians demonstrated authority but were not authoritarian.

"Well, I suppose you accept that part [the physios are in charge]. They're the ones that's going to set the programme and you're the one to carry it out and that." (OP6: 186-187)

Clinical knowledge and expertise was the greatest influence on older patients' perception of professional hierarchy in the relationship they had with their physiotherapy clinician. Some patients felt the hierarchy to be absolute and obeyed the clinician unquestioningly. Other patients felt that a certain hierarchy was inevitable and necessary in order to demonstrate the clinicians' knowledge and skill, which enhanced confidence and compliance. Most physiotherapy clinicians were described as using their professional power appropriately and effectively without belittling the patient.

"Well, they know, they've got more knowledge. Oh yes, it's definitely to do with their profession. Well obviously, I mean if you happen to be the one who's in pain and they can give you something... you see they know... you don't know probably." (OP5: 302-309)

"I find it's their attitude towards you and (pause) umm... if you know that you can trust them and they're not being over powerful - although they know more about what they're doing than what you do, they don't give you that impression." (OP4: 335-338)

One patient attributed the increase in information exchange in clinical encounters to service changes rather than any individual clinician's characteristics.

"I mean I know it's policy these days, they do explain things more to you so you do know what is going on and what isn't going on. No, I find altogether they were quite... they were very helpful. But they weren't over powering." (OP4: 393-396)

Most recognised that the sharing of personal information was unequal but saw this as entirely appropriate, appreciating the need for them to impart the personal information necessary for their rehabilitation. Older patients relied on the perceived professional confidentiality of their clinicians to assure them that this inequality was apposite.

"I don't feel it[sharing personal information] does [alter the relationship at all] because if they are as they should be, right, what they know is they keep to themselves." (OP5: 132-135)

Many older patients identified the way in which they were addressed as an indicator of a less hierarchical encounter. Although all had been asked how they wished to be addressed, patients varied in whether they liked this or not. It is not known whether patients felt they had any true choice in this decision.

"They said could they call me by... would I mind, by my Christian name and I said 'Oh no'. I used to think that was a bit, you know, a bit much. But that was the way I was brought up, you see. I was brought up, I suppose you could say, quite Victorian." (OP11: 250-251, 261-263)

Some patients attributed positive impacts to the relationship if patient and physiotherapy clinician were on first name terms.

"You get to know them very well. You know, you're on Christian name talking, like, which I think is one of the biggest things you can do because I don't like being called Mr P and so I said "My name's J" and that's it, you know. Well, it's got a friendly atmosphere, you know. Cos if you's talking to all of them in their, say Christian names, you say to them 'Bob' and all to the rest of them, you're all talking so it becomes a happy kind of environment that you're in." (OP6: 69-72, 114-117)

One patient was persuaded to accept being called by her Christian name as she felt it encouraged a closer relationship.

"Also I think that, first of all I thought this Christian name business, I didn't know whether I liked it or not, but I think it can help sometimes instead of someone sitting there calling you say Mrs M all the time. If they call you by your Christian name you feel that you are that little bit closer." (OP4: 346-350)

Interestingly, older patients were completely unable to distinguish between physiotherapists and physiotherapy assistants despite their different uniforms and roles. Therefore it was not possible to explore the different hierarchy issues arising from the physiotherapy clinician data to discern whether older patients felt they were in a manipulative situation when qualified physiotherapists appeared to be using the closer relationship between physiotherapy assistant and older patient to extract more information.

"Err.. but I'm not quite sure whether they are equal or whether one is slightly above the other but they seem to be more or less umm... I honestly, I don't know." (OP5: 85-86)

It appears from these findings that the majority of older patients interviewed in this study identified the presence of professional hierarchy describing it in a positive light. It would seem that they expect a defined and disciplined hierarchy and are relieved when they find a more relaxed atmosphere. However, they need some hierarchy to give structure to their experience. It appears to add to the patients' feeling of security within an alien environment.

5.6.5 Pre-existing Factors

Older patients described several factors that they felt were intrinsic to the encounter. These included their pre-existing personal characteristics and those of their physiotherapy clinicians, service factors of time, continuity and treatment environment, prior knowledge of physiotherapy and the way in which they approached their rehabilitation.

All patients bring with them their past experiences of life and health care and their own set of beliefs and attitudes that inform the relationship and their engagement with their episode of care.

The older persons' narratives of their life experiences prior to their illness gave some insight into their response to the relationship. For example, one older woman described balancing her life in domestic service with her own family, characterised by obedience to her husband and employers.

"Yes, I had a family of three, two girls and one boy. I had them to look after. Cos that's what my boss said to me one day. She said "One thing Mrs W" she said "Your family never have to.... never go without a meal." I said "Wouldn't do for them to, I'd have my husband after me". (OP1: 239-242)

This obedience was reflected in her obedient role in her physiotherapy encounter.

"She just told me what to do and I followed her, you know. I did what she told me to." (OP1: 60-61)

One older woman felt that she engaged well with physiotherapy, as she was familiar with exercise having been an athletic person in her younger days.

Previous occupation also influenced the way in which the patient engaged with their physiotherapy clinician. One participant had previously worked as a nurse and, although this was many years previously, felt she understood the structure and functioning of the healthcare system that paved the way to a closer understanding and relationship with her physiotherapy clinicians. A male patient who had worked as an accountant described the relationship as *"professional and encouraging"*. He did not expect nor seek any friendship but did view the physiotherapist as a fellow professional.

"She seemed to know exactly what she was doing... I think she did her job with me, getting me walking. That was the main purpose. It was to get me on my feet again." (OP7: 76, 89-91)

Recalling other relationships also appeared to influence the way in which older patients approach the encounter. One woman described the breakdown of her marriage when her children were young and expressed some bitterness that she had been left to cope alone.

"Well, yes because I had a husband who decided to walk away. He couldn't face the fact of bringing up the children I think. I think he just couldn't face the responsibility of them." (OP4: 450-452)

It is possible that this experience had made her able to stand up for herself, something that she expressed she was able to do in difficult situations when she was on the ward.

"I didn't like the attitude of some of the nurses down there. You had the impression that because you'd had a stroke they thought your brain had gone. Unfortunately I used to say what I thought. A lot of the people ... didn't like the way they were treated but they wouldn't say anything. They seemed to be a little bit scared of saying anything, where I didn't." (OP4: 166-172)

However, another older patient expressed surprise that she was considered worth treating at 89 years of age, an approach that, she felt, encouraged her to engage fully with rehabilitation.

"Well, there was no sort of umm.... attitude "Well, you're nearly ninety, what can you expect, you know" none of that. It was treating you as someone who should have hope and confidence." (OP10: 126-128)

The personality of the clinician was seen to play an important part in establishing rapport. A nice manner was felt to instil confidence.

"She'd [physiotherapy assistant] got a very nice manner and umm... yes. I think you get more confidence and some, I say, has got a nice manner like that. Yes. I've always found her very good, every time." (OP8: 66-71)

As most of the participants were describing positive experiences of physiotherapy it is not surprising that the majority of characteristics noted were positive.

Important personal characteristics that older patients felt physiotherapy clinicians brought to the encounter were related to their interpersonal skills including their approach, ability to engender hope, being encouraging and being interested in the

patient. Other characteristics described as being embedded in the personality of the physiotherapy clinician were a having a caring nature, patience and being genuine, inspiring and helpful.

Some older patients felt that the characteristics of their physiotherapy clinicians matched their ideal image of the person who should be doing this job.

"To be quite honest I think they were in the right job. I said that to myself many times that they're people in the right job. You know, cos some people, they stick out like a sore thumb and they don't do what you feel... They were good for me anyway. I think they got me as far as what I was, you know...." (OP3: 318-322)

Some physiotherapy clinicians were described as knowing intuitively what the patient wanted and when they had had enough. This built trust and encouraged patients to work hard as they felt that their physiotherapist would not push them beyond their capacity.

"I think she realises if you are getting a bit tired that she'll say to you "You've had enough for today and we'll see you tomorrow" or whenever you know. But there was no forcing you to do anything or anything like that. I mean sometimes you did feel that "Oh no, I can't do that again" but you realised that the more you did it, it was helping you." (OP4: 65-70)

Intuition was not confined to the physiotherapy clinician. One older patient described that he could sense the attitude of the clinician and that this was important to the way in which he engaged with the clinician and the therapy.

"I'm a pretty perceptive sort of person and I can sense whether they are really in it err... for me, or whether it's just a job." (OP9: 305-306)

Some physiotherapy clinicians were described as showing confidence in their patient. This had a very positive effect on the patient's engagement with the clinician and treatment. The physiotherapy participants did not note this characteristic and it may be that they do not appreciate the impact of demonstrating this trait.

"And the physiotherapist was confident that I was one of them people that would actually do the exercises. I think she realised that I was a pretty determined sort of a person. So it wasn't necessary for her to come in everyday cos she knew that I would do them [exercises] anyway." (OP9: 28-36)

Only one negative personality characteristic of physiotherapy clinicians was described. One participant described a depersonalised approach to the intervention that prevented a relationship developing giving her a demoralising impression of the rehabilitation experience.

"No, you'd be lined up with the teacher out in front "Right, we do this". Exercise and then with bars... and you couldn't say no. "You CAN do it, You CAN do it"... Well I suppose you could have said no but the thing was, my aim was to get well and get out. But by the same token I appreciated that this was necessary to get fit." (OP2: 49-60 edited)

The gender of the physiotherapy clinician was not an issue for most of the older patients. Five older patient participants identified having seen male as well as female physiotherapy clinicians during their episode of care. One male patient preferred female physiotherapists because they could *"sweet talk me into doing my exercises"* (OP6: 278) and one older woman commented on being treated briefly by a male physiotherapy student.

"... and we had a young fella. He was training. He was good. [Name] he was, he was a coloured chap. He was a lovely fella, yeah." (OP3: 30-32)

Apart from these two comments that appear to be related to factors of engagement between people of opposite gender rather than being physiotherapy specific, no one commented on any issues of or problems with gender difference in the encounter or relationship.

Several comments were made about the value of such service delivery characteristics as time and continuity of treating personnel. Most of the older patients differentiated

between the relationships they associated with health care professionals identifying the time and continuity spent with the physiotherapy clinician in a Day Hospital or domiciliary setting as making an important contribution to the strength of the relationship.

"They wanted to make sure that you achieved the best result and they would spend time. Now, no doubt they've probably got another dozen people to see in that day, but the good ones I found didn't show that they had other people to see, they were prepared to concentrate on you and they made you feel that you were the one that they wanted to help." (OP9: 107-112)

However, this was not the case with the physiotherapists they had seen on the wards who was described as having less time and appearing more rushed.

"I found that as an inpatient with some of the physios - I'm not saying it was their fault, I wouldn't blame them because if they're run off their feet then they've got so many more people to see, they maybe can only spend so much time with each person and I feel perhaps that's one of the areas that could have been improved, you know." (OP9: 281-287)

Continuity of physiotherapy clinician was felt to be very important. Older patients valued getting to know people and seeing familiar faces at each treatment session. They equated this with physiotherapy clinicians having a greater interest and inside knowledge into their problems and rehabilitation. Having had the time to get to know the clinician engendered trust and *"brings you out more" (OP5: 101).* Seeing the same person each time saved time going over old ground and allowed rehabilitation to progress more steadily. In particular, patients got used to the clinical approach of the physiotherapy clinician and did not have to relearn each clinician's way of working, and in particular, their handling skills. Having continuity in a good relationship gave older patients the confidence to confide problems that they might have felt inhibited about sharing with strangers.

"...you looked upon them more as a friend coming in and you'd look forward to them coming because you would immediately think about the person and in their absence

you're thinking about them and wondering how they are and thinking of the things you can talk about next time you see them and also other little things you don't mind talking about your body to them." (OP2: 296-301)

The expectations of older patients also influenced their approach to the encounter including the relationship. Anxieties about treatment were easily dissipated by the physiotherapy clinician's response.

"I... at first I think I thought I'm not going to like this very much because I ... I thought it would be a bit like school "You will do this and you will do that". But it wasn't like that at all. It's the way she approached it was... extremely helpful, didn't sort of make you feel that you were inferior or anything like that, or as I used to say, "a bit of a wally." (OP4: 81-88)

One patient with previous experience of physiotherapy described good and poor relationships with physiotherapy clinicians, describing how past physiotherapy treatment had not helped him.

"Well I had about three or four courses [of physiotherapy] over 22 years so umm... to be honest they tried everything and I never found that any of the physio did me any good at all, it probably made me worse." (OP9:447-450)

Interestingly this previously unsatisfactory outcome of physiotherapy had not impacted on his desire or ability to engage in good physiotherapy clinician/patient relationships and he described his most recent course of postoperative physiotherapy as very helpful alongside a good relationship with his physiotherapist.

Whilst it is expected that the health care professional will work within a particular paradigm or frame of reference (Helman, 2001: 13), older patients too enter into the physiotherapeutic encounter with a coherent system of explanation to account for the origin and nature of the problem and how it can be dealt with. Although the older patients in this study did not explore the cause and reason for their ill health or disability, all came to the encounter with explanations of how it could be dealt with. As previously identified, some patients felt that obedient compliance was required

whilst others identified collaboration and one negotiated his role and responsibilities in a form of partnership. Where physiotherapy interventions were described as poor or ineffectual, compliance still remained. Where relationships were described as poor, no one in this study felt able to challenge the physiotherapy clinicians, preferring to collaborate in order to remove themselves from the situation as quickly as possible.

However, patients did identify some intrinsic personal characteristics that they felt contributed to the relationship. Older patients described themselves variously as "careful", "placid", "independent", "hard working" and "cheeky"; all personal characteristics that they felt informed the way in which they engaged with their physiotherapist. Another characteristic that some older patients felt they brought to the encounter was motivation. In one person's case, this motivation was stimulated by medical advice and past experience.

"I think a lot of it [motivation] came from me... I was told by the surgeon himself and the physios that ummm... they've done their part and yet the rest of it was down to me. (OP9: 51-55)

"I had a relative and she had an accident and she just would not do the exercises ... And she was a permanent invalid for the last ten years of her life. And I didn't want to get to that stage where I was going down the same road. (OP9: 75-81)

5.6.6 Professional Factors

Patients felt that physiotherapy clinicians brought knowledge, professional expertise and skill to the encounter. These were intrinsic to the encounter but the patient's appreciation of these factors were formative in the development of the relationship.

Professionally physiotherapy clinicians were felt to demonstrate professional judgement, expertise and knowledge that they presented in an accessible way. However, in isolation, a purely professional approach was felt to be lacking in the skills needed to engage with the patient.

"Even though the physios may have the technical skills ... if you don't build a relationship so you've got trust in them, actually, all the clinical skill in the world it's a waste of time, yeah." (OP9: 193-198)

Patients were uncertain as to whether they brought any specialist knowledge to the encounter being more likely to describe personal information about their previous abilities and home circumstances as sharing of self to assist in assessment.

The older patient participants recognised that physiotherapy clinicians came to the encounter with pre-existing skills relating to their professional training and experience. The very physical nature of physiotherapy may have been expected to embarrass or upset older patients in particular who may have had less liberal ideas about undressing and touch than younger people. However, this was not the case with the older patients in this cohort who had all been prepared to submit to close physical contact and therapeutic touch. Their trust in the physiotherapy clinician relating to touch appeared to rest entirely within the clinician's professional skills and status. Even older patients reporting poor relationships with their physiotherapy clinicians had no problem with the physical side of the encounter suggesting that in these elements of the encounter professional skill and status is more important than the quality of the relationship.

"Well I suppose you would have to expect something like that wouldn't you [touch limbs] because umm... if they didn't that meant that anybody could do it. And if it was important for them to watch how your muscles are moving, I mean... it would be no point in them going through all that training... I mean, what's the point [feeling embarrassed]. If they're going to make you better you put up with everything, you know, and anything, you know." (OP9: 539-543, 550-551)

Interestingly, some older patients denied that they had needed to undress, expose limbs or be touched during their treatment. Given the clinical conditions they received physiotherapy for and the treatment they described this seems unlikely in all cases. This would seem to reinforce the finding that the older patients are accepting of physiotherapeutic touch and do not express any strong feelings about this or being undressed during physiotherapy treatment.

5.6.7 Impact on outcome

Whereas the physiotherapy clinicians defined clinical outcome as the impact of their intervention on the mobility, function and well being of their older patients, the older patients themselves described a broader definition of outcome. This definition portrayed their current attitudes towards and understanding of their illness and recovery, their current health, functional ability and coping strategies and their future prognosis. Thus the term 'clinical' is omitted from this sub category.

In this study all the older participants described health gain from their episode of physiotherapy care. Even the one patient who felt that physiotherapy had made him worse in the early stages of his condition described how physiotherapy had optimised his recovery following surgery.

Most of the older patients attributed their health gain to the intervention rather than the relationship. However, it is clear that enhanced quality of life relating to increased morale, increased knowledge of physical problems and their management and, in some cases, seeing the physiotherapy clinician as a friend, was achieved through the relationship elements of the encounter.

"I'm sure it [taking a personal interest in the patient] does [impact on recovery]. I feel that she was interested in me as a person getting better." (OP7: 254-255)

However, all the older patient participants felt that the relationship they had with their physiotherapy clinician impacted on the outcome of their episode of care. Liking the clinician was important as participants felt they were more likely to feel comfortable and comply with someone they liked. In this respect older patients see the onus on the physiotherapy clinician to develop a good relationship with them.

"Yes, I wouldn't be at all surprised [if the relationship impacts on recovery] because I think, I think if you took a dislike to somebody... no that wouldn't help you, because you'd be afraid, I think to ask for something, or... wouldn't you, just in case." (OP11: 235-238)

"If you've got somebody that you're not - let's face it - is not appealing to you, or you feel isn't helping or you feel perhaps they're a little bit... You don't get that same cooperation." (OP5: 70-77)

Although some older participants complied with physiotherapy in the absence of a good relationship to enable them to end treatment as quickly as possible, most denied that intervention alone effected a satisfactory outcome.

"Oh I wouldn't [have got on so well if there hadn't been a good relationship], no. No because just the exercises... the fear would still have been there. That was the main thing, the fear." (OP10: 329-330)

No one, however, considered that the relationship in isolation had the same therapeutic impact.

Sharing of self within the relationship, that allowed the older patient to see the physiotherapy clinician as a person as well as a professional, was felt to impact on compliance and clinical outcome without detracting from the clinician's professional stance.

"It's ... they are human the same as us. The same as the patient and therefore you then give yourself more to them. I think it speeds up the healing process." (OP2: 444-446)

One older patient described the interaction as vital to assuring her of her own capabilities and potential. This inspired confidence to engage in the therapy and had a positive effect on outcome. Another participant, following a dense stroke and considerable physiotherapy, remained physically dependent and had been obliged to move into sheltered accommodation from her family home of over fifty years.
It is interesting that, despite this, she was very positive about the relationship and its effect on her limited recovery.

" They inspire you, you know. You think to yourself "Oh well, S[name of physiotherapist] said I could do that and that's alright". You know, cos you've got to have something that you can hang onto haven't you, you know." (OP3: 228-236)

This participant did not perceive any discrepancy between the physiotherapist's encouragement and positive outlook and her eventual limited recovery.

5.7 Conceptualising the relationship: the older patients' perspectives

In summary, the aims of the study have been addressed though the findings set out in this chapter.

Most older patients recognise that a relationship exists between themselves and their physiotherapy clinician. This relationship is usually seen as good and conducive to feeling comfortable with treatment through information sharing, trust, confidence and an appreciation of the human as well as the professional nature of the physiotherapy clinician. In the two cases where a relationship did not appear to exist, the older patient responded with passive obedience or appeared totally self-absorbed and self-sufficient. In neither of these cases did the older patient expect or seek a relationship with their physiotherapy clinician. Poor relationships occur where communication skills are limited and there is a reluctance of either party to share personal elements of themselves. The quality of service delivery also impacts on the relationship.

As with the physiotherapy clinicians, the older patients felt that a relationship was integral to the encounter, existing because of, alongside and time limited by the treatment intervention. As with the clinicians, they too did not feel that the relationship was therapeutic in isolation.

In identifying the rationale for the relationship, older patients felt that the quality of the relationship impacted greatly on their engagement with the intervention, their compliance and the eventual outcome. They also used it as a vehicle for confiding fears and gaining information. No evidence was found in this cohort of older patients manipulating the relationship in order to extend their episode of care or gain favours usually outside the remit of the physiotherapy clinician.

The level of engagement varies between patients on a continuum from unquestioning and passive obedience through sharing of self on different levels, a friendly relationship to friendship and, finally, dependency. Older patients who have not experienced physiotherapy previously are unsure of what sort of relationship is expected within the encounter and take the lead from their physiotherapy clinician, possibly mirroring their engagement. The impact of the relationship on some patients was found to continue after the episode of care ended, in particular those relationships experienced by patients as having an emotional component. There are various possibilities for this. From a purely pathological stance this may be related to emotional lability associated with the impairment. Alternatively, patients may be truly upset by the closure of a relationship that is important to them. In addition, the two patients recalling this response may have been reacting to their significant social changes following profound, sudden onset disability that had not resolved fully with physiotherapy.

A key factor arising from the data that impinges on the relationship is the way in which the older patient approaches their physiotherapy episode of care. Helman (2001: 13) suggests that patients and clinicians have coherent systems of explanation of the origin and nature of health problems and how they can be dealt with. Older patients in this study approached their episode of care with pre-existing attitudes and beliefs, past experiences of health care and physiotherapy and their expectations of the treatment. In particular the experiences and lifestyle of older people and the potential for a "generation gap" could distinguish older patients' engagement with the relationship from that of physiotherapy clinicians and younger patients. Factors of concern to the physiotherapy clinician cohort including hierarchy, professional power and touch were seen as an inevitable and expected part of the encounter by older patients. Similarly, partnership, deemed important and something to be strived for by physiotherapy clinicians was not given any great credence by the older patients.

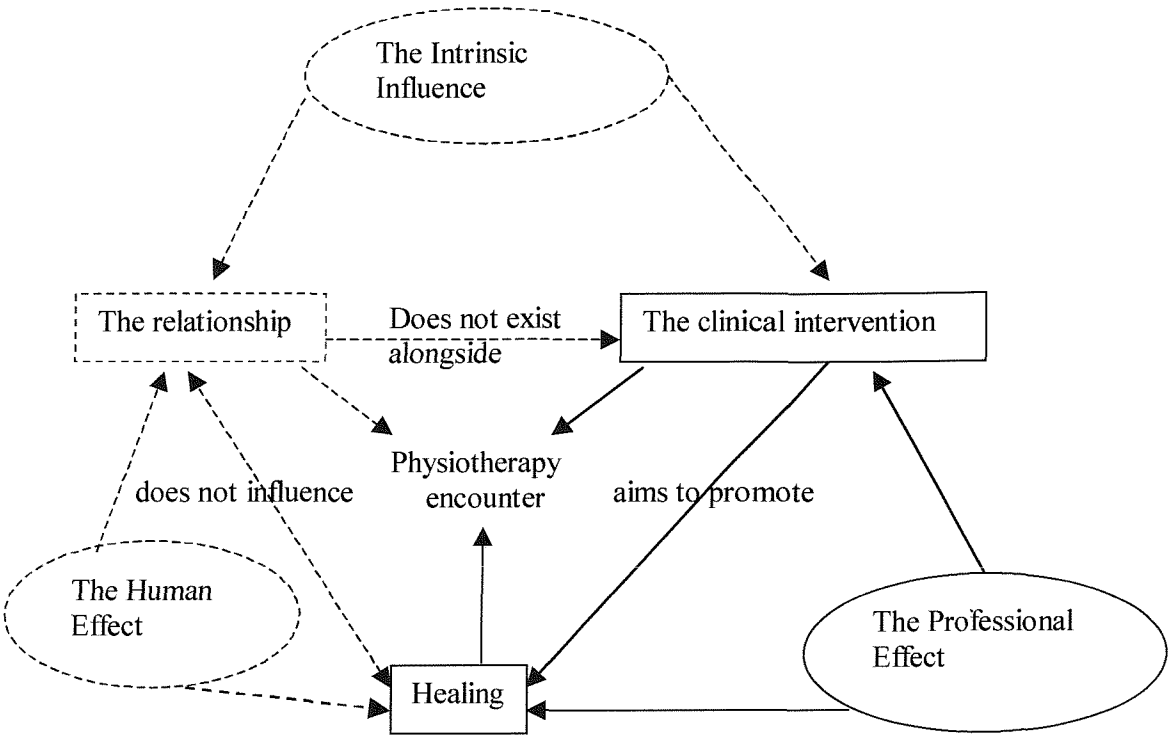
5.7.1 Model 1: Placing and conceptualising the relationship within the physiotherapy encounter

Many of the perceptions and experiences of the older patient reflect those of the physiotherapy clinician. All, in the main, acknowledge the existence and importance of the relationship that occurs between them in the clinical encounter. As with the

physiotherapy clinicians, where a relationship was felt to exist, older patients described the relationship as being present alongside and because of the clinical intervention, confirming Figure 4.3 Model 1a: Placing the Relationship within the Physiotherapy Encounter, derived initially from the clinicians' data. The same concepts of the Intrinsic Influences, the Professional Effect and the Human Effect were also evident as in Figure 4.4 Model 1b: Conceptualising the Relationship within the Physiotherapy Encounter. Two older patients in this study did not perceive a relationship to exist, one unable to remember the physiotherapists who treated her in a social rehabilitation unit and another who appeared totally self sufficient and detached from any clinical relationship. In these cases the model of the role of the relationship in the physiotherapeutic encounter categories (Fig 4.3) and concepts (Fig 4.4) are adapted as shown in Figure 5.3 below.

In the absence of a relationship, healing is still able to occur but is effected only by clinical intervention with no mediating effect of the relationship. The Professional Effect is the key component of the episode of care relying solely on professional knowledge and clinical skills to achieve a clinical outcome. In both these examples there was evidence of weakened Intrinsic Influences and Human Effect. Intrinsic Influences including the patient and therapist approach, pre-existing attitudes and beliefs and the influence of service delivery were still evident but there was little evidence of trust and cooperation determined by anything other than blind obedience related to the patient's perception of professional hierarchy. The Human Effect was evident in the patients' willingness to engage with the physiotherapy clinicians' instruction, albeit in a detached way. They reported answering questions but not wanting to engage in any voluntary self-disclosure. There was no evidence of humour, of seeking reassurance or of wanting to engage with the clinician as a person. A good relationship is said by other clinical and patient participants in this research to promote trust, compliance and optimise outcome. Where the relationship was absent in these cases, it appears that trust and compliance were present but driven by obedience, an acceptance of professional hierarchy and a belief in professional skills of the physiotherapy professional. There was no evidence of any attempt to work with the physiotherapy clinician in the identification of treatment goals. It is not possible to judge whether optimal outcomes were achieved in these two cases.

Figure 5.3 Adapted model of the physiotherapeutic encounter where the relationship is absent.



The poor relationships described by some older patients as linked to poor communication skills and lack of self-disclosure also fit into this model. Here a weakened Human Effect leads to reduced confidence and lack of reassurance that these patients describe as having different effects on outcome. Some describe not achieving optimum outcome or taking longer to achieve it due to concerns that they are not doing the right thing. As previously noted, one older patient described working hard despite a poor relationship with her physiotherapist so that she could end the episode of care as quickly as possible.

5.7.2 Model 2: Older Patients' Perceptions of the Relationship

Physiotherapy clinicians and older patients identified similar views about the constituents of the relationship that developed between them within the physiotherapeutic encounter. Figure 5.4 illustrates the older patients' perceptions of the relationship that include the existence and course of the relationship, constituents

Figure 5.4 Older patients' perceptions' of the therapeutic relationship

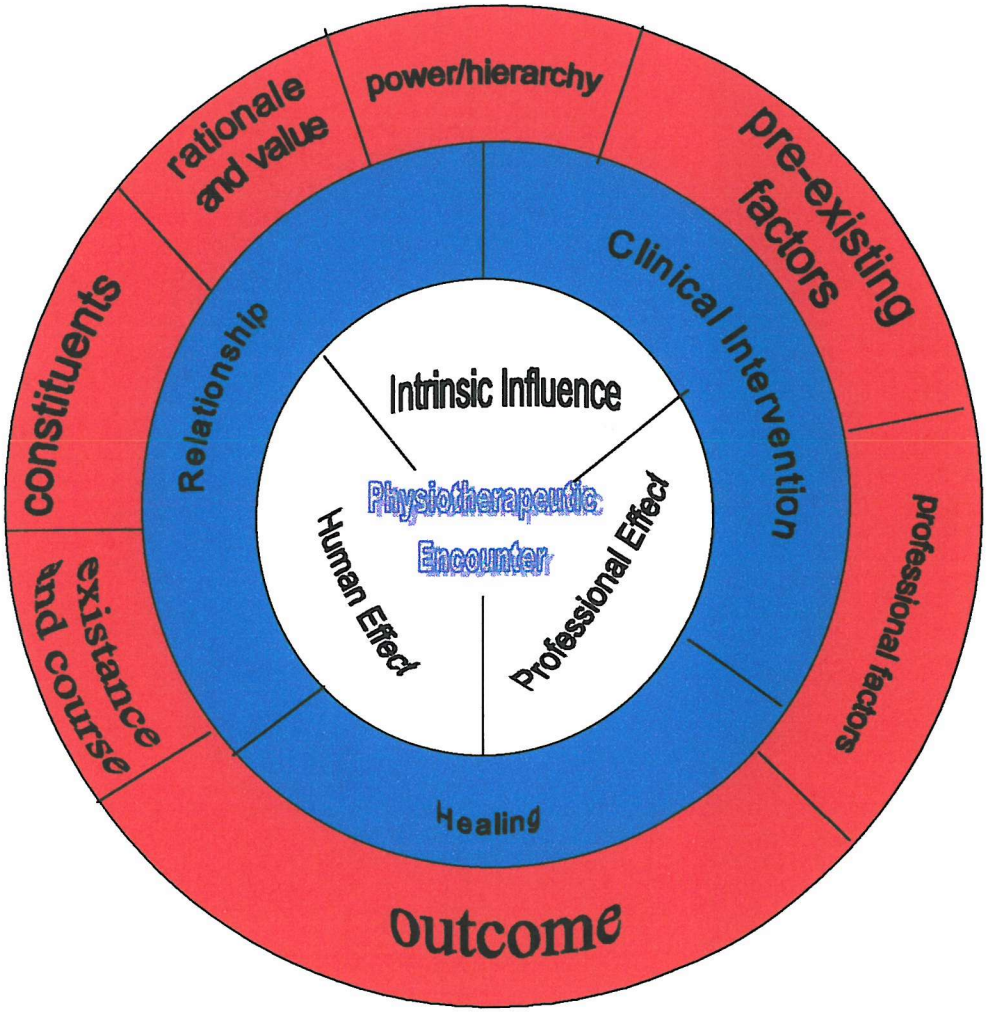
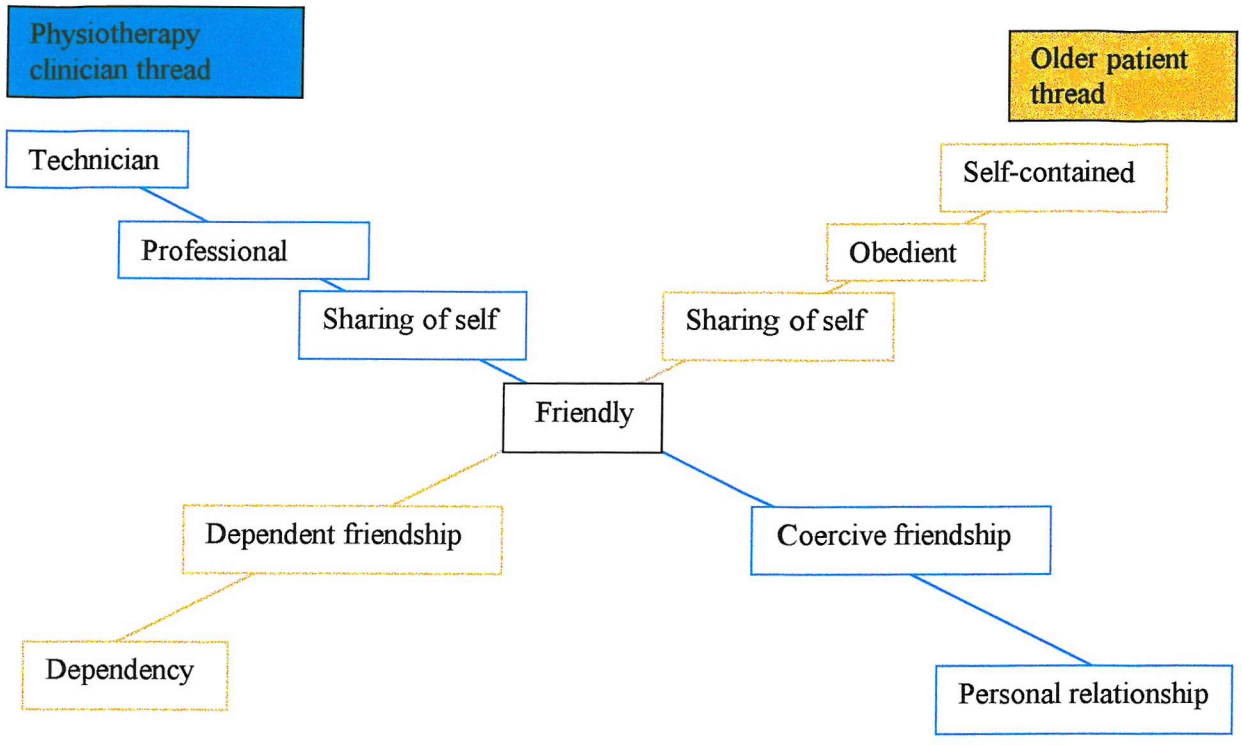


Figure 5.5 Levels of engagement in the physiotherapy clinician / older patient relationship.



Description of terms:

Friendly – described by both parties as a reciprocated relationship where selected personal information is exchanged and a degree of confidence is established leading to trust and mutual respect. Unspoken but accepted social boundaries and the physiotherapy clinicians' professional code of conduct are maintained.

Physiotherapy clinician thread

Technician – minimal engagement with the patient. Often a single encounter, impairment driven.

Professional – the clinician remains entirely within their professional persona, often distant, choosing not to share any human elements of themselves. Mostly described by qualified physiotherapists rather than assistants.

Sharing of self – this occurs on different levels ranging from use of personal information to encourage or inform patients, to every day chit chat, to enough self disclosure to demonstrate the human side of the clinician.

Coercive friendship – this is said to occur infrequently and is deemed to be on the edge of professional bounds. Here the physiotherapy clinician uses an overtly friendly approach to coerce the older patient to engage with treatment or make decisions. It could be deemed manipulative.

Personal relationship – only one example was found of this. Here the relationship was actively cultivated after the patient was discharged and gifts were accepted by the clinician. It is not known how active the older patient was in the initiation or continuation of this relationship. Such relationships are considered by most physiotherapy clinicians to be outside professional bounds.

Older patient thread

Self contained –the patient is entirely self absorbed and self contained and does not seek a relationship within the encounter.

Obedient – the patient does not relate to the clinician in any other than an obedient way.

Sharing of self – older patients disclose their personal selves to different degrees varying from just enough information to facilitate assessment, through to deep personal anxieties considered unrelated to their direct rehabilitation. They often seek some reciprocation from the physiotherapy clinician.

Dependent friendship – a degree of physical and emotional dependence on the physiotherapy clinician is displayed.

Dependency – here patients perceive the relationship to be more important than the treatment. They may describe profound distress at the closure of the relationship.

of the relationship, the rationale and value of the relationship, professional power and hierarchy, pre-existing factors, professional factors and impact on outcome. Although these categories are similar to those identified by the physiotherapy clinicians there are some differences, in particular in perceptions of professional power and institutional hierarchy, partnership, touch, friendship and dependency as previously described in section 5.6.

5.7.3 Model 3: Levels of Engagement within the Physiotherapy Clinician/Older Patient Relationship

Both the physiotherapy clinicians and the older patients identified different levels of engagement within the relationship (Figures 4.2 and 5.2). Both ranged on a continuum from what could be considered an absent or minimal relationship to one that could be construed as aberrant either through patient dependency or physiotherapy clinicians exceeding their professional bounds. Each continuum is described as a thread. Figure 5.5 illustrates the association between the two threads. They cross at the midpoint of both where physiotherapy clinicians and older patients described the relationship as "friendly".

This Levels of Engagement model is a key concept arising from the data with both physiotherapy clinicians and older patients describing the relationship as having professional and friendly elements. Friendship is a recurring theme from the older patients data whereas physiotherapy clinicians describe using a friendly approach to deliver their professional and clinical responsibilities rather than overt friendship. The professional elements describe the way in which the physiotherapy clinicians portray themselves in a professional role having knowledge, expertise and authority whilst the older patient generally responds in deference to this, acquiescing compliantly within the encounter. These two studies of physiotherapy clinicians and older patients suggest that both engage in the relationship at different levels, often moving between the human and professional ends of the continuum as circumstances dictate.

These varying levels of engagement can be seen as roles being played out, perhaps unwittingly, by both parties. Both physiotherapy clinician and older patient appear to adopt two main roles (human and professional) within the encounter, relating to the

wider concepts of the human and professional effects previously identified in Figure 4.4 Model 1b and against the background of intrinsic influences of pre-existing service and personal characteristics.

The final study explores this supposition that both parties play differing, dual (professional and human) roles in the relationship and considers the impact of this on the relationship and possible implications for the older patients' rehabilitation. These issues are developed in the final observational study (chapter six) and discussed in chapter seven.

5.8 Reflecting on the Study

Interviewing older patients for this study was reminiscent of working as a clinician in an elderly services rehabilitation unit. I was surprised how easy it was to adopt a researcher rather than a physiotherapeutic role. This was probably due to the patients being unaware of my clinical background so preventing them from drawing me into clinical topics. In addition, their physiotherapy episodes of care were complete when I saw them and I avoided picking up any clinical cues from them that stimulated my therapist interests.

Interviewing older patients on the topic of relationships made me reflect on whether I formed any kind of relationship with them during this research. I already knew several of the physiotherapy clinicians prior to their interviews but this was not the case in this study. Certainly I was well received by the majority of the older participants who were eager to share their experiences. One older person, who described a very obedient response to her physiotherapist behaved in a similar fashion with me, happy to answer questions but not volunteering any further personal information.

I consider that I was able to facilitate an open rapport during these interviews. This rapport could be described as friendly in that it was polite and contained elements of good interpersonal communication skills on both sides. There was evidence of listening, empathy and respect. This facilitated self-disclosure from the participants. Relating these research encounters to Adam's et al (2000) typology of elements of social friendship, some elements, namely self disclosure (sharing of self), trust and

respect were present as was a purpose to the encounter – data gathering. Other elements such as frequency of contact and commitment were neither present nor necessary.

The situation where one person gives information and the other uses that for a broader purpose could be deemed unequal and I was very aware of this during these encounters. Careful adherence to ethics guidelines, giving assurances of confidentiality and anonymity and clearly showing respect for the participants' views were used to reduce the effect of this inherent hierarchy. I also tried not to abuse the participants' willingness to help and allowed time before and after each interview to engage in more social "chit chat" if the participant chose. Several older people were eager to show me their gardens or photographs of their grandchildren. Several were keen to make me a cup of tea and talk of non-clinical related experiences. I was happy to comply as they had, after all, paid me the compliment of talking about topics of my choice for an hour or so. I felt it was a way of paying back their assistance allowing them to choose the agenda for a few minutes more and attaining some kind of equality in the encounter. No one sought any personal self-disclosure from myself and I did not feel it appropriate to offer any. Although these engagements were friendly they could not be construed as friendship, strictly professional or dependent.

The models developed from this part of the study arise from only eleven older participants who were recently discharged from seven dedicated elderly rehabilitation services of four NHS Trusts. Although a sample size of twelve was originally mooted, eight from Portsmouth Trusts and four from the Chichester Trust, it was eventually decided to recruit only three from Chichester. This was due to staff shortages within this day hospital that meant all the potential participants were being treated by the same two physiotherapy clinicians. Practically, this impacted on the time and goodwill of these clinicians to identify and approach potential participants and methodologically meant that each patient interviewed was relating their experience of the same clinicians, potentially limiting the experiential data gathered from the older person cohort. When ethical approval was first obtained, there were five physiotherapy clinicians working in this unit that would have had the capacity to broaden the data gathered. As the data was analysed between interviews it became clear that a wide range of views and experiences (see 5.6) was being obtained from a

broad range of older people (see 5.5). It was therefore decided not to go back to Portsmouth Ethics Committee to recruit another older person to this arm of the study but rather to continue to develop and test the existing analysis and theory within the final case studies.

Classically, grounded theory methodology studies recruit relatively small samples (see Methods chapter section 3.7.1.2) aiming for depth of analysis rather than any attempt at generalisation of experience. Data gathering must, however, continue until theoretical saturation is achieved in the coding (Glaser, 1969). Although the cohort was small, the key categories arose from each participant and the differing perspective of each older person meant that a range of views was expressed within each theme. Themes are also known in grounded theory as sub categories. These informed the categories and concepts already identified in the physiotherapy clinicians' study. It could be argued that the older persons' data has been manipulated to fit the model and that the analysis could have been different had this data been gathered first. It is acknowledged that it is impossible to analyse the later data in isolation having already identified the experiences and perceptions of the physiotherapy clinicians. However, given the similarity of the themes arising from the older patients' data and the fact that a common experience was being explored, it seemed appropriate to code and conceptualise the older patients' data in a similar way. This did not prevent the identification of different codes in several of the themes. The categories and concepts remained the same. It is also acknowledged that this study did not build in a means of feeding back the findings to older patients in order to check the appropriateness of the model in the same way as occurred in the physiotherapy clinicians' study. Given the dispersed nature and diversity of medical conditions of a population of older people discharged from physiotherapy rehabilitation, this could not be undertaken readily without entering another prolonged ethics committee application. However, to address this gap the key findings of this study together with the models generated formed part of the post observation interview discussions with the older participants in the final study (Chapter 6).

5.9 Summary: Consolidating the physiotherapy clinician and older patient perspectives.

The key concept arising from the physiotherapy clinicians' and older patients' data so far relates to the differing levels of engagement taken by patients and clinicians in the relationship. These vary from no engagement in technical or obedient encounters to relationships that many see as inappropriate and undesirable namely those leading to dependency or personal relationships within the episode of care. These levels of engagement demonstrate themselves in the different roles played by participants in the encounter where physiotherapy clinicians may adopt professional and /or friendly roles dependent on the approach they deem appropriate. Similarly older patients may present as both passive, sick patient and friendly, eager pupil. This opens the potential for conflict between the professional and human elements of the encounter.

Physiotherapy clinicians feel very bound by their professional code of conduct and qualified physiotherapists particularly by a reluctance to be drawn into friendship which they may need to compromise through the necessity to use their clinical authority to impart difficult information that an older patient may not want to hear such as ending the episode of care. However, they actively use their interpersonal skills of communication, empathy and self-disclosure to engage the older patient and engender trust and compliance. Qualified physiotherapists may deal with this conflict by separating the two roles, keeping the professional assessment and discharge role for themselves whilst encouraging the physiotherapy assistant to engage on a human level and become friendly with the patient to facilitate full engagement with treatment. The recent guidelines in the National Service Framework for Older People (DOH, 2001a) are also inadvertently helping physiotherapy clinicians to manage their human and professional discomfort at discharging older patients through facilitating the gradual withdrawal of involvement by encouraging long term support and follow up particularly for people with stroke or people at risk of falling. However, the impact of this unusual pattern of a friendly relationship on the older patient may be confusing and profound.

Many older patients enter the encounter with expectations rooted in past health care experiences. They may expect well-defined patient and clinician roles and initially feel surprised or uncomfortable with the informality of first name usage and less

formal service structures. The one frame of reference that informs their place and role in the encounter, professional hierarchy, is also under threat from the move towards negotiated partnership, something that is unfamiliar and not sought by many of the older patients in this study. Their response to the clinician may mirror the approach of the physiotherapy clinician by responding in a friendly or professional manner and this supposition is explored in the final case studies. Certainly older patients appear to gauge their initial response according to the physiotherapy clinicians' approach. Wanting to engage on a familiar human level, appear compliant and give something back to the clinician, they often disclose elements of themselves beyond that required for assessment and treatment purposes. In return some have expectations that the physiotherapy clinician will reciprocate as a friend would in a social situation and indeed this seems be the case particularly in the physiotherapy assistant / older patient and longer-term physiotherapy clinician / older patient relationships noted by the research participants. In circumstances of profound life change where older patients have to manage loss of physical and life style independence, the physiotherapy clinician can appear to be the one stable influence who also offers the hope of returning to the old abilities. In these circumstances it is unsurprising that some patients grow to regard the relationship as more important than the intervention and become dependent on their physiotherapy clinician.

Thus older patients may experience conflict initially when trying to ascertain whether a professional or human interaction is required. For some older patients further conflict may arise later in the relationship where the friendship they consider they have made with their physiotherapy clinician is terminated at the end of the episode of care conflicting with their past experiences of the process of social friendships. Whilst older patients know in theory that this will occur, the emotional contribution they have made to the relationship over-rides this head knowledge and does nothing to diminish their sense of loss at the end of the episode of care.

These conclusions suggest that both physiotherapy clinicians and older patients are adopting different, varying, possibly dual roles within the relationship and are therefore operating with unintegrated worlds of professional expectation and human identity. The relationship between them occurs through a negotiation of experience and expectation, usually led by the physiotherapy clinician. In addition, the

physiotherapy clinicians describe the relationship as being an important precursor to partnership with their older patients in their rehabilitation. However, the older patients have little understanding of this concept as defined by the clinicians.

The final study seeks to explore these concepts of role, friendship and partnership within this inherently hierarchical liaison through the observation of the relationships presenting in four individual physiotherapeutic interventions and follow up interviews with all participants.

Chapter Six
The Relationship in Action

6. Introduction

This study commenced in December 2002.

It comprised an exploration of four single physiotherapy clinician/older patient interventions occurring within medium to long-term rehabilitation settings. Each involved the observation of a physiotherapy treatment followed by individual interviews with the physiotherapy clinicians and older patient involved. These investigations were undertaken in the elderly medicine departments of the same NHS Trusts accessed in the previous two studies.

An observation guide was developed (Appendix 6.1) informed by observation methodology (Mason, 1996: chapter 4) and the findings of the previous two studies. Interview guides for the physiotherapy clinicians and the older patients were developed from those used in the earlier studies (Appendices 6.2 and 6.3). These were also adapted to allow for questions to be asked about the findings of the observations.

This chapter outlines the aims and objectives of these investigations, participant sampling, data collection, undertaking and findings. The ways in which these case studies add to the earlier findings and contribute to theory development are discussed. As in the earlier studies a grounded theory approach was used.

6.1 Aims and Objectives

The aims and objectives of these investigations were to build on the previous findings.

Aims:

1. To test Model 1, Placing and Conceptualising of the relationship within the physiotherapy encounter (figures 4.3 and 4.4) and Model 2, Participants'

Perceptions of what Comprises the Physiotherapy Clinician / Older Patient Relationship (figures 4.5 and 5.4) within individual therapeutic encounters.

2. To explore the appropriateness of Model 3, Levels of Engagement model (fig 5.5) within individual physiotherapy clinician/older patient relationships.
3. To explore the roles of the participants as identified in the previous two studies within individual interventions to ascertain:
    a. What these role are
    b. Whether multiple roles exist
    c. How these roles are perceived and managed, including any potential for conflict
4. To consolidate the findings from all the studies and clearly identify the key concept(s) that underpin(s) the physiotherapy clinician/older patient relationship in medium to long-term rehabilitation settings.

Objectives:

1. To observe treatment sessions where individual patients are being treated by a physiotherapist and/or a physiotherapy assistant in order to:
    a. Gain another perspective (the researcher's) on the process and possible effect of the physiotherapy clinician/older patient relationship.
    b. Allow specific issues relating to the relationship observed in that intervention to be identified for later exploration with each participant.
2. To interview each participant following the observed treatment session to gain information and insight into their perceptions of the relationship in this encounter, including its development and role.
3. To specifically ask participants about the models arising from the previous studies to test their appropriateness.
4. To use the findings from this study to test previously identified models, clarify the core concept(s) and develop a theory using a grounded theory approach.

6.2 Participant Population and Sampling

Following the previous two studies where perspectives of physiotherapy clinicians and older patients were obtained in isolation, frequently resulting in information about several relationship experiences, it was decided to explore individual relationships. This format gave the opportunity to observe individual dyads within a treatment session and explore the perspectives of both parties individually about the same encounter and see if the models arising from the previous data could be applied to specific relationships.

To ensure parity of service culture and organisation these treatment sessions were drawn from the same NHS Trusts as the previous two studies. Ethical approval was obtained to undertake four individual studies, one in each of the four participating Trusts. Unfortunately, under the terms of the ethical approval it was not possible to identify potential participants and encounters without the assistance of the treating physiotherapists. Although this had the advantage of ensuring that the patients approached were cognitively and linguistically able to participate it meant that, as gatekeepers, the treating physiotherapists were able to screen out encounters that they would prefer not to be observed or explored. This has been a problem throughout the data collection having the potential to present findings based on a biased population.

Physiotherapists working in the elderly rehabilitation services were approached and asked to participate and identify potential patient encounters for inclusion in the study. The interventions had to fulfil the following criteria:

- Involve patients undergoing medium to long term rehabilitation physiotherapy within the Trust elderly services
- Treatment undertaken in outpatient, day hospital or domiciliary settings
- Involve an older patient (over 65 years) and a physiotherapy clinician (qualified physiotherapist and /or physiotherapy assistant)

Theoretical sampling was undertaken where possible to explore specific areas as the interview and observation guides developed between case studies. This involved identifying key topics arising from the early case analysis and actively seeking cases where these topics could be explored further. An example is the early finding that a

physiotherapy clinicians' experience may impact on the way these relationships are managed. For a later case an encounter between an older patient and an inexperienced, junior physiotherapist was therefore sought and obtained. The full purposive sampling criteria appear at appendix 6.4.

Due to problems accessing patients and staff from one of the Trusts another Trust identified two patients and their physiotherapists from two different services in different geographical areas.

Table 6.1 Individual investigations: participant and environment characteristics

	Venue	**Patient**	**Physiotherapy clinician 1**	**Physiotherapy clinician 2**	**Length of relationship**
Case 1	Out patient	- male - 73 years - L CVA - Lives with wife	Senior clinical specialist physiotherapist	Physiotherapy assistant	Five months with both clinicians as in and outpatient
Case 2	Day Hospital	- female - 75 years - L CVA - lives with daughter's family	Senior 2 physiotherapist on rotation	Physiotherapy assistant	Eight months with physiotherapist, occasional only with PTA
Case 3	Day Hospital	-female -83 years - Parkinson's disease - Lives alone	Senior 2 physiotherapist based in DH eight years	none	One month, Four treatment sessions
Case 4	Patient's home	-male - 75 years - R CVA - lives with wife, wider family very involved	Junior physiotherapist on rotation	None directly involved, although senior PT supervises occasional session	Two and a half months, including two weeks whilst inpatient

CVA – cerebro-vascular accident (i.e. stroke)

PTA – physiotherapy assistant

6.3 Exploring Individual Interactions

Four cases were explored in this study. Four patients (Two male, two female, age range 73-83 years) were observed being treated by physiotherapists and (in two cases) also by physiotherapy assistants. All patients, due to sampling and ethics requirements, were well into their treatment programmes and had established relationships with their treating therapists. Each physiotherapy clinician and older patient participating within each observed intervention was interviewed within a week of the observation, before the next treatment session. Observation was not used as a means of data triangulation to assure validity but simply as a means to note issues and behaviours arising within the treatment session to seek further clarification from participants at their interviews (section 3.5).

The data from these cases were analysed using a grounded theory approach as before in order to explore whether findings from specific, individual relationships reflected previous participants' views of general physiotherapy clinician/older patient relationships and the models that arose. The interview and observation guides were based on findings from the previous studies. However, the researcher tried to remain open to the possibility of new concepts and interpretations through asking questions of the participants based on observation of the treatment session and through continual reflection on the process and interpretation. The findings are presented below.

6.3.1 The Rationale, Role and Constituents of the Relationship

The findings from these individual cases support the previously identified models relating to the rationale, role and constituents of the physiotherapy clinician/older patient relationship. These are included, briefly, below as they are mostly repetitive of the comments made by participants reflecting on less specific physiotherapy clinician/older patient relationships. No new sub categories arose from these cases. This appears to confirm the earlier models and suggest that they may be applied to individual cases.

In each case, all participants acknowledged that a relationship existed between themselves and their therapist/patient. This existed alongside, because of and inextricably entwined with the therapeutic encounter.

These participants felt that the role of the relationship was to establish a rapport.

"I would say, almost before you need to do any assessing you need to chat to the patient and make them feel at ease. I think the most important thing is for them to feel they can tell what's really worrying them." (Case 3, physiotherapist, 417 - 420)

to put patients at ease and facilitate trust by disclosing some personal details;

"You automatically ask them are you married? Have you got any children? You automatically ask them that... Well, it's nice to know you're getting to know them, their personality and that. (Case 4, Older patient, 572- 573, 578)

and to optimise clinical outcome.

"Your outcome I think is linked very, very strongly to the relationship you build up with your patients and if you don't have that relationship then I don't think your outcome will be as good." (Case 2, physiotherapist, 339-343)

Where the patient failed to achieve an activity there was no evidence of frustration or annoyance on the part of the physiotherapy clinicians, rather a return to simpler, more achievable exercises. No evidence of patronising in this approach, rather empathy and reinforcement of good outcomes which then went on to build towards achievement of the treatment goal (sit-stand unaided). (Field notes, reflection on case 2, 204-209)

The essence of this therapeutic encounter comprised the same professional effects, human effects and intrinsic influences as were found from the initial interviews with physiotherapy clinicians and older patients in the earlier studies. Identical constituents were both observed and identified from these observed encounters. For example, one of the professional factors 'boundaries' was observed in Case 4.

[Patient and his wife] asked [physiotherapist] how she had enjoyed her holiday. [Physiotherapist] said it had been good but did not go into any detail (Case 4 field notes, 51-52)

The physiotherapist in this intervention stated that the relationship was bounded by the professional reasons for the therapeutic encounter. She described how the boundaries between physiotherapist and patient could vary in different situations.

"Yes, very just professional, but I'm trying to say, I mean, it's still, it's not that it's not professional if it's more relaxed but at the same time - like I know I can tease [this patient] and I know I can have a bit of a joke with him whereas there are other patients that just wouldn't." (Case 4, physiotherapist, 417-420)

The human effect identified in these interventions is illustrated by observation and patient identification of the constituent 'trust'.

[The physiotherapist] moved treatment on by saying "Hope you don't mind if I remind you how to stand up." [Patient] "No". [Physiotherapist] anticipated [patient's] anxiety "We're right here with you even though it feels funny. We wont let you fall". [Patient] seemed comfortable with this and happy to comply. (It would appear that [physiotherapist] and [physiotherapy assistant] pick up [patient's] anxieties through her hesitation and tentative body language.) Much gentle encouragement used to encourage standing. (Case 2 field notes, 113-119)

One patient acknowledged the element of trust in his clinicians.

"You've got to have faith in them, that what they're doing is helping you." (Case 1 patient, 294)

Similarly, the intrinsic influences within the encounter were found to have resonance with both patients and physiotherapy clinicians in these studies. An example of these

intrinsic influences, 'the environment', was a common thread here. One patient described the friendly atmosphere of the day hospital and its impact on her.

"Where we all sit together, we're all patients. And the nurses have their uniforms on, that sort of thing. Oh, they all just come and sit down and chat and talk, you know, there's no ruling where they mustn't do it or anything like that, you know. They're very nice.

Interviewer: Yes. Does that make you feel more comfortable being there?

Oh yes, yes definitely, dear."

(Case 3, patient, 34-40)

A physiotherapist reflected on her feelings at having to treat her patient in his own home after having worked with him as an inpatient.

"I suppose when you're in hospital you're very much on ... I'm on my ground sort of thing and I'm, you know this is my physio gym and this is where I work and I bring you into my gym and we do this, where as, I think that first session when you go and see somebody at home, it's always a bit awkward. If they don't invite you to sit down, you're like "Ooo, do I sit down or do I wait to be invited?"" (Case 4, physiotherapist, 589-595)

The similar findings in the individual cases suggest that Models 1 and 2 (figs 4.3, 4.4, 4.5, 5.4) previously identified are appropriate in individual prospective relationships as well as in those recalled by participants describing (in many cases) multiple encounters and associated relationships.

6.3.2 Levels of Engagement in the Relationship

The level of engagement model devised from the earlier studies was similarly tested in these individual cases.

The level of engagement in the relationship between the physiotherapy clinician(s) and the older patient in each observed encounter was established through observation and agreed with them during interview questioning. The levels of engagement identified in each relationship are plotted below against the model of engagement (fig 5.5). In the figures, the oval shapes refer to the older patient and the rectangles to the physiotherapy clinician. Participant quotes are identified by case, participant and text code.

Case 1: 73 year old married man, five months into his treatment for stroke with senior physiotherapist and physiotherapy assistant.

The older patient in this case perceived his relationship with the senior physiotherapy clinician as friendly.

"It's friendly but not a proper friendship" (Case 1, Older patient, 441)

The senior physiotherapist perceived her relationship with this older patient as ranging between professional and friendly as circumstances dictated.

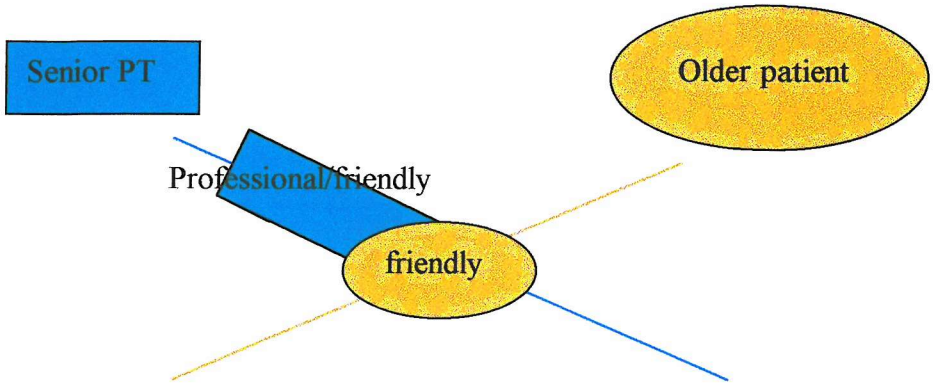
The relationship between senior physiotherapist and patient appeared to be slightly more formal with the senior physiotherapist directing the session and keeping it on a clinical track. The PTA and patient appeared to have a more friendly relationship with some self-disclosure on the part of the patient. No significant self-disclosure was observed from either senior physiotherapist or PTA. (Case 1, field notes reflection, 166-171)

When questioned about these observations the senior physiotherapist stated;

"I'm probably, a little bit more restrained than say [the PTA] is. ... there's a little bit of me that holds back because I am the therapist and I don't want them to see me as being just a friend because I have to be quite firm sometimes." (Case 1, Senior physiotherapist, 179-183)

Figure 6.1 illustrates the levels of engagement within the relationship described by the senior physiotherapist and older patient, based on the levels of engagement model (Fig 5.5) developed from the earlier studies.

Figure 6.1 The case 1 senior physiotherapist/older patient relationship as described by both participants



The older patient perceived his relationship with the physiotherapy assistant as friendly.

'Researcher: "Did you get on differently with [senior physiotherapist] to the way you got on with [PT assistant]?"

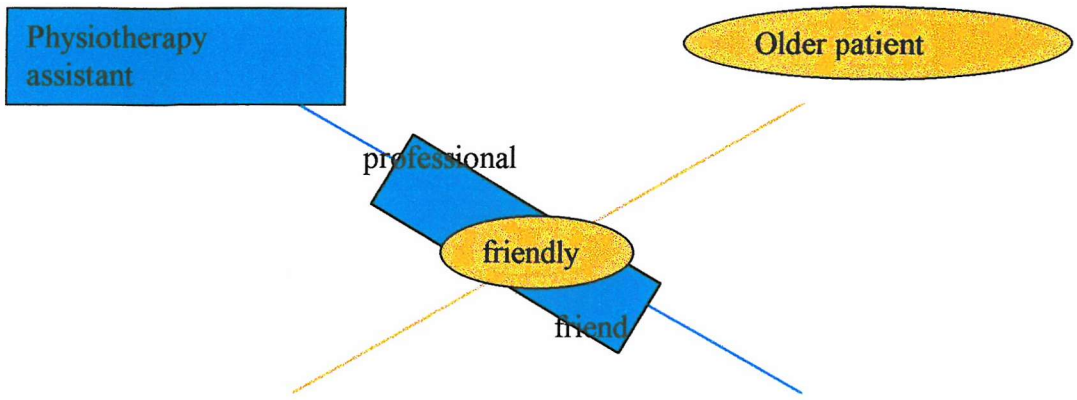
Patient: "No, they're both the same".' (Case 1, Older patient, 265-266)

The physiotherapy assistant described her relationship with this patient as friendly and verging towards friendship but becoming more professional as circumstances require. She described humour as playing a key part in pitching the relationship.

"You've got to really be sure of that person's sense of humour because that's, I think with him, that's what makes the friendship." (Case 1, Physiotherapy assistant, 109-110)

Figure 6.2 illustrates they way these participants described their relationship.

Fig 6.2 The physiotherapy assistant/older patient relationship as described by both participants



In this case the physiotherapy clinicians and the patient had known each other for a long time and had developed a relationship spanning the early stages of the patient's considerable disability and his subsequent slow and incomplete recovery. The physiotherapist stated that she maintained a professional relationship with a friendly approach. The physiotherapy assistant also alleged a professional approach; although from both observation and participant interviews it appeared that her manner was much more allied to the patient mainly through humour. This was used to maintain a human angle and lighten difficult moments. The patient described a friendly relationship rather than a friendship. The relationships described were also observed during the interaction. The relationships described by the clinicians were not static but fluctuated with the situation, particularly where the patient was perceived to have reduced compliance with treatment. The senior physiotherapist encouraged the physiotherapy assistant to develop a more friendly relationship to optimise compliance. She expanded on her rationale for maintaining a professional stance with this patient whilst promoting a friendly PTA/patient relationship by reflecting on her wider work experiences. This participant felt that being the senior clinician she was perceived as *"the boss"* by patients and their relatives and this prevented a friendly relationship from developing whilst ensuring that her expertise was recognised and complied with through this professional hierarchy. She described a *"two pronged attack"* if a patient was *"hard to win over"*. She felt that she

and the physiotherapy assistant played a *"good cop, bad cop"* role with patients, where the roles varied according to circumstances. She did not feel that this role-play was a problem as the two clinicians worked together so closely as a team.

"We're always saying we're good cop, bad cop, you know. ...if you're not badged up and looking important then they don't think you're sort of... not an important person, but they don't think you're in charge. They're not particularly interested. But of those people, they don't tell you the personal stuff but they might tell [PTA] because [PTA] they don't see as being a physio, they know that she's not and they are more likely to tell her things that are bothering them that they wouldn't tell me. ...they want to be treated by me but they'll tell [PTA] the other bits. So again, it's a whole mix and match thing really." (Case 1, Senior physiotherapist, 246-264, edited)

The senior physiotherapist thought that professional hierarchy was an important and necessary constituent of her role.

"...but I think you can have a great time with somebody but you know the boundaries umm... but for them to respect you, you mustn't let them lose the respect for you as a professional." (Case 1, Senior physiotherapist, 365-367)

She was, however, careful to distinguish between professional and personal hierarchy. For example, she considered that hierarchy depended purely on circumstance as illustrated by this quote.

"There's nothing hierarchical about the fact that I'm a physio. What I have got is some skills that they need at that time. But equally, if you had a plumber for instance on treatment, they may well have skills that you need at some time. So it's just that sharing out of skills. But at the time that they've had their stroke they need you. When a plumber comes to your house you don't stand there and say "Well I'm a physio actually". Because that makes no difference." (Case 1, Senior physiotherapist, 433-444, edited)

She described how she actively reinforced her professional role where necessary through establishing her professional hierarchy if a patient was perceived to overstep relationship boundaries or ceased to comply with treatment.

"... and I might get quite strict with them sometimes and I might even, on occasion, if I feel they haven't taken on board what I've said, I might even write them a letter on the ward. Umm... and put it in writing so that they, not in a nasty way, but to make them realise perhaps they're doing something I've told them and told them and told them I don't want them to do and it's going to slow their progress and I might put it in writing and I'll give it to them so that they think "Oh, right, okay". It doesn't happen very often but I've got that ability to do that. I know that that's something that works." (Case 1, Senior physiotherapist, 198-206)

Although the relationship between clinicians was not under scrutiny in this research, it was apparent that the long standing working relationship between the senior physiotherapist and the physiotherapy assistant was important in the way they managed both their relationships with this older patient and his treatment. The physiotherapy assistant in particular appeared to fluctuate easily between roles, first demonstrating a friendly complicit relationship with the older patient, laughing at his jokes to the exclusion of the senior physiotherapist, then a professionally obedient role carrying out the senior physiotherapist's instructions and finally a professionally exclusive role where she exchanged verbal and non-verbal communications about the patient's clinical status and treatment with the senior physiotherapist whilst actively excluding the patient. She did not see any discrepancy between these roles when interviewed, feeling that any variation in relationship emphasis was driven by clinical need and therefore within her professional frame of reference.

In summary, in this case all parties saw the relationship as good and assisting engagement with treatment. The senior physiotherapist identified having two roles within this relationship. She presented a professional role when applying clinical treatment, becoming firm when the patient appeared not to be taking her advice seriously and yet

engaging with humour in a friendly chitchat rapport. Similarly the physiotherapy assistant presented a professional face when being drawn into a clinical role by the senior physiotherapist whilst maintaining a complicit, friendly rapport with the patient, a role she described as *"being a friend"*. The patient believed that his engagement with both clinicians was consistently friendly and appropriate to his role as patient.

The treatment session ended with the patient walking from the treatment gym into the physiotherapy department kitchen area and the importance of a cup of tea after the treatment seemed to indicate the end of the formal therapy session and signal a shift in the relationship from professional to human, with both physiotherapy clinicians shifting into their friendly roles. All participants alluded to the value of this in passing and without prompting during interview and the making and drinking of tea was observed at the end of the physiotherapy treatment encounter. All saw it as a welcome break after a demanding treatment, almost a reward for working hard. Making a cup of tea in a therapeutic setting is more often associated with occupational therapy and there was no obvious reason why this should be occurring as part of this physiotherapy treatment, for example as a means of developing standing tolerance. The physiotherapy assistant said she had often brought this patient to the department for a cup of tea in his early inpatient treatment days as a place of refuge to diffuse problems associated with his frustration. It would appear that this simple ritual is actually quite important here, allowing the older patient to engage in something normal within an abnormal situation. This was seen as quite a natural thing to do and not employed as a conscious delineator between professional and friendly relationships.

Case 2: 74 year old widow, eight months into her treatment for stroke with senior physiotherapist, also assisted by physiotherapy assistant

In this case, the older patient and senior physiotherapist had known each other in ward and day hospital settings for the eight months since the patient had been admitted with a stroke. It was clear from the observation that each knew the other well and had an easy relationship.

There was good, easy engagement between [senior physiotherapist] and [older patient]. [Senior physiotherapist] gave her lots of encouragement that was well received. (Case 2, field notes, 75-76)

Although the participants related well there was no evidence of friendship from either interviews or observation. The older patient in this case described her relationship with the senior physiotherapist as one of obedience.

"I mean, I don't mind what she tells me to do I try to do it, you know." (Case 2, Older patient, 149-150)

During the observed treatment the older patient did not share any personal information other than that required for assessment and treatment purposes, neither did she describe any sharing of self during the interview. She was pleased, however, that the senior physiotherapist shared some personal information as this reduced the impact of professional hierarchy and made her feel more comfortable in this situation.

"And then she told me she was expecting a baby and it was nice to have talks like that with her, you know... It makes her bring herself down... well not down to your level, but... cos I always look on her with her job being higher than me, you know." (Case 2, older patient, 110-115)

The senior physiotherapist was happy to share limited personal information with this lady as she felt it showed her human as well as her professional side, but felt that developing a friendship with her was inappropriate in these circumstances.

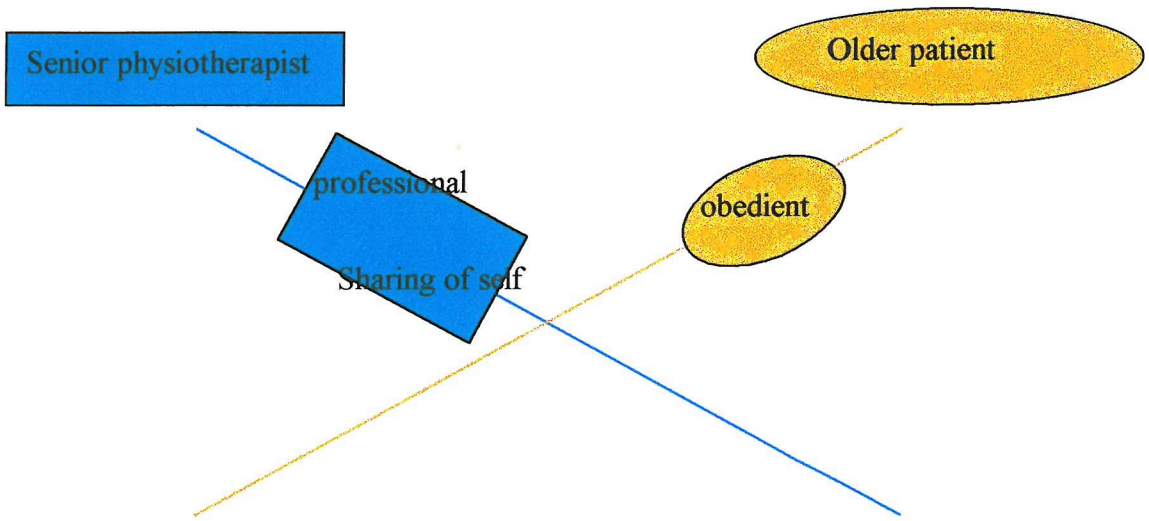
"I wouldn't say it's a friendship. Not because I wouldn't like to be friends with [older patient] but I think that I do keep my distance because of the situation that we're in. The relationship as it is, is a working relationship... is a working relationship for me." (Case 2, senior physiotherapist, 443-446)

She explained her pregnancy disclosure as a purely human exchange but also as a way of informing this patient that she would be going on maternity leave and would not personally be completing her course of treatment.

"I think you've got to give a little bit as well or you can come across I think as being quite... well... it's just not human really." (Case 2, senior physiotherapist, 159-162)

Figure 6.3 illustrates the level of engagement within the senior physiotherapist/older patient relationship as described by each participant.

Figure 6.3 The case 2 senior physiotherapist/older patient relationship as described by both participants



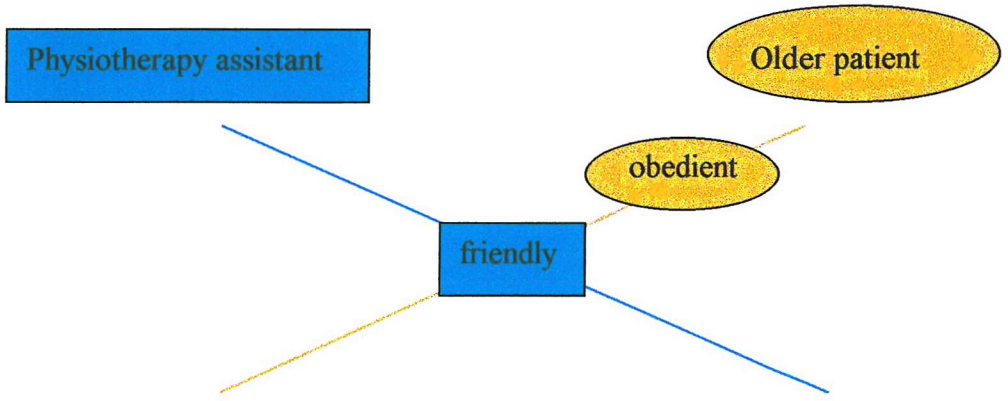
In contrast to this longstanding relationship, the physiotherapy assistant observed in the treatment session had only met this patient on a few occasions. However, she described her relationship with this patient as friendly.

The physiotherapy assistant described a conflict between her desire to develop a friendly relationship in order to alleviate the difficult experience of hospitalisation for the patient

and her own professional and personal boundaries. She recounted the importance of her friends to her, describing friendship as a mutual support system. Although she felt it her role to support the older patient she did not seek any reciprocation at that level. She also drew boundaries in order to protect herself in the event of the patient's death.

"I would say it's a friendship but not a friendship. I try not to get too involved cos that's my biggest thing cos with my friends, I'm really close to all my friends, I tend to help them out a lot and I'd help anybody but I think there's a boundary. I don't want to get too emotionally involved with people because if they suddenly had another stroke or suddenly die, it would be like losing my friend which I think I'd find quite hard." (Case 2, Physiotherapy assistant, 329-337)

Figure 6.4 The case 2 physiotherapy assistant/older patient relationship as described by both participants



The relationships in this case existed exclusively alongside the therapeutic intervention and there was no expectation or desire that any relationship would continue beyond this. The pleasant nature of the mutual engagement clearly engendered trust and mutual respect. It allowed enough openness for important information and fears to be expressed but left neither party open to manipulation or dependency. This relationship differed from others described by older, widowed, female patients in that it was set against the background of good family support, suggesting that this older patient either did not appear to feel the need to develop further supportive relationships within her treatment

setting or perhaps simply just did not feel it appropriate to form a relationship with a clinician.

This older patient had moved from her own house since having her stroke and was living in an annexe of her nurse daughter's house. On the visit to interview this lady it was apparent that her independence was being encouraged and carers rather than the family were addressing most of her personal needs. On the surface it appeared that this lady was making her own decisions about her rehabilitation. However, her daughter was well acquainted with NHS policy and procedure and had written a letter of complaint containing a well argued, evidenced based case for more physiotherapy treatment for her mother. When interviewing the senior physiotherapist it was clear that this letter had been written with her knowledge and support as a means of pressurising managers into reconsidering physiotherapy staffing levels within the day hospital. The older patient had apparently been quite passive in this decision but knew of it and frequently asked whether she was going to have more treatment. Although the therapist/relative relationship is not under scrutiny in this research it clearly influenced the physiotherapy encounter for this patient as the positive outcome of this action benefited both parties. Its effect on the clinician/older patient relationship is not known.

In summary the long term relationship between the senior physiotherapist and this older patient remained at the professional level with the physiotherapist maintaining a professional role, sharing enough personal information to reinforce her human attributes of empathy and understanding. The older patient maintained her role as pleasant, obedient patient whilst her nurse daughter firmly insisted on her rights to more treatment. The older patient also displayed an obedient role with the physiotherapy assistant who described her own approach as friendly.

As in the previous case, the relationship seemed to shift from friendly to professional as circumstances dictated with the physiotherapy assistant engaging the patient in friendly chitchat and humour on the way from the patient waiting area to the treatment area where both deferred to the more professional approach of the senior physiotherapist.

Case 3: 83 year old widow referred for assessment of early Parkinson's Disease, observed at her fourth treatment session with a senior physiotherapist

This case also identified a professional encounter determined by the characteristics of the short-term nature of the encounter, the environment and the attributes of the senior physiotherapist and older patient. No physiotherapy assistant was involved in this patient's day hospital care.

"A trusted professional friendship, yes. Because I think there has to remain a degree of detachment from it. So, yes, I do think it's a type of friendship. It's perhaps a bit more akin to a teacher pupil relationship in some ways, because they feel that you're the person they can ask." (Case 3, Senior physiotherapist, 136-140)

Both older patient and senior physiotherapist separately described their relationship as one of teacher/pupil. The older patient felt that she was able to separate the therapeutic encounter from any relationship although she appreciated knowing that the physiotherapist had a human side as well.

"Well I mean, you're there for a purpose aren't you, it's the physio. It's not like a Mothers' Meeting and things like that where you would talk about your family and all the rest of it. But it's nice if they introduce somebody in their family or they may say "My daughter does this" or "My son does that"". (Case 3, Older patient, 490-498)

The senior physiotherapist felt that this older patient did not seek any relationship with her as her physical improvement meant that difficult life style changes did not need to be addressed and her existing social support provided any friendship she may need in the treatment setting. During observation the older patient was seen to engage with fellow patients, one of whom was a long standing friend, in a friendly, open manner.

"I think in her case it [the therapist/patient relationship] probably isn't so important. I feel that she is really very good and I think perhaps that influences it. She's seen herself

improve so much that a lot of her needs have been fulfilled by her physical achievements... I also don't think she's lonely which many of our patients are and I think again a lot of the private conversation would have gone on already with this friend [another patient] that she already knew here." (Case 3, Senior physiotherapist, 215-225 edited)

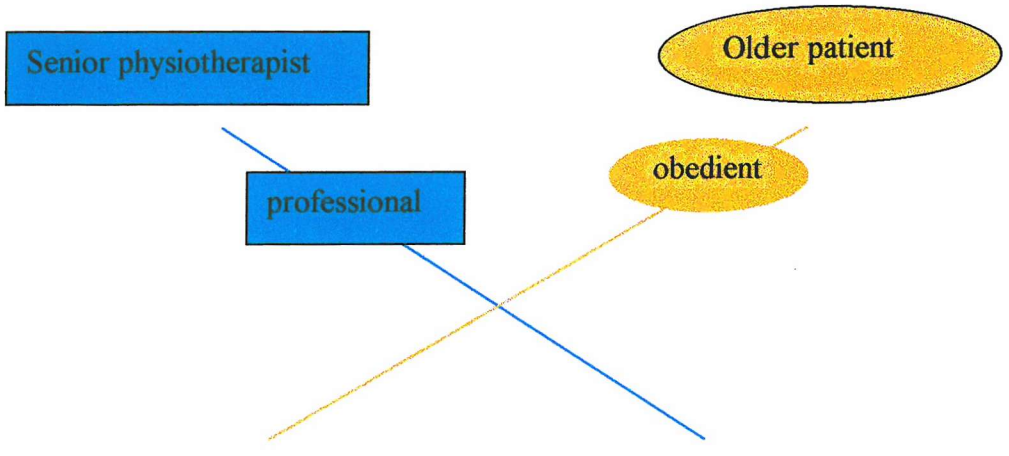
There was no evidence of self-disclosure from either party, although the group treatment environment of this encounter did not encourage this. Whilst the older patient was obedient to the physiotherapist's instructions, she had no qualms about moving from one activity station to another without waiting to be told (field notes, observation, case 3).

"You want to please them because they're doing their best to help you, aren't they." (Case 3, Older patient, 308-309)

Her remembrance of treatment from a physiotherapy assistant whilst an inpatient illustrates the pupil/teacher relationship, naughty/good response that she describes with humour.

"Cos I had me legs crossed like I've got 'em crossed now, he [PTA] used to come along and give them a good slap and he used to say "You're doing it again!" you know. (Laughs)" (Case 3, Older patient, 204-206)

Figure 6.5 The case 3 senior physiotherapist/older patient relationship as described by both participants



In summary, although this case is characterised by the professional stance of the senior physiotherapist and the obedience of the older patient, a pleasant rapport existed between them that maintained distance whilst engendering mutual respect and trust. In contrast to the previous two cases, the physiotherapist maintained this approach when fetching the patient from the waiting area. Friendly interchange and mutual support was observed between patients in the group. Interestingly the senior physiotherapist interpreted these friendly relationships as a reason for not needing to develop more friendly relationships with older patients herself. As the manager of the service this senior physiotherapist had the authority to change from group to individual treatments. Admittedly there may be significant service or clinical reasons why group treatment is preferred but another reason could be that unwittingly she recognises the value of a friendly atmosphere whilst being able to retain her professional detachment without compromise. Where other physiotherapists manage the potential professional/friend role conflict through their judicious use of physiotherapy assistants, in the absence of such an assistant in this environment it could be seen that the patient group interaction was performing this role.

Case 4: 75 year old married man, two and a half months into his treatment with a junior physiotherapist for stroke. Currently receiving domiciliary physiotherapy.

This case was different from the previous three in that the physiotherapy treatment was taking place at the patient's home and the close, extended family played a key and intense part in the older patient's rehabilitation. This was illustrated by the older patient's insistence that his daughter be able to participate in his interview and his request for a transcript *"Cos the wife will want to know word for word what I said"*. This close family involvement is illustrated in fig 6.6.

The junior physiotherapist was inexperienced in working with long term, neurological patients and with working in the domiciliary environment. Although she had the clinical support of a senior physiotherapist it became apparent that her relationship with the senior physiotherapist had been adversely affected by the apparent conflict between the senior physiotherapist and the older patient and his family, something the junior

physiotherapist was trying to ameliorate whilst maintaining a good relationship with the patient herself.

Although both junior physiotherapist and older patient described a good relationship engendering trust there was considerable observation and interview evidence suggesting different understandings. This was particularly evident in the physiotherapist's and older patient's perception of goal setting.

"I feel I've got a reasonably good relationship with him and... Just because I've got to know the family dynamics I'm able to work my treatment around that and, you know, I know what they're trying to achieve and what they may or may not achieve and because of that I know where I'm going with the treatment and I'm pretty certain what the outcome's going to be. He's had a lot of problems coming to terms with the fact that he may not walk again. I think that perhaps I've got a true picture of how he feels about things." (Case 4, Physiotherapist, 487-494)

The older patient and his daughter had a different perception of what the treatment was aiming towards.

Patient's daughter: "Yes, she's full of encouragement. She really boosts him, really works hard."

Interviewer: "Yes. Does she think that you're not going to walk again?

Patient's daughter: "She doesn't like to say."

Patient: "She won't commit herself" (Case 4, Older patient, 138-142)

The junior physiotherapist described her relationship with the older patient and his family as one of the family, yet still the health care professional.

"Well I think that I'm part of the family there. I think I'm always going to be [K] the physio to them but I think at the same time they'll also have a laugh and have a joke and they'll bring up other problems so... B's [Older patient] having some dental problems and I was able to give some advice on where to go to find a dentist. (Case 4, Physiotherapist, 109-113)

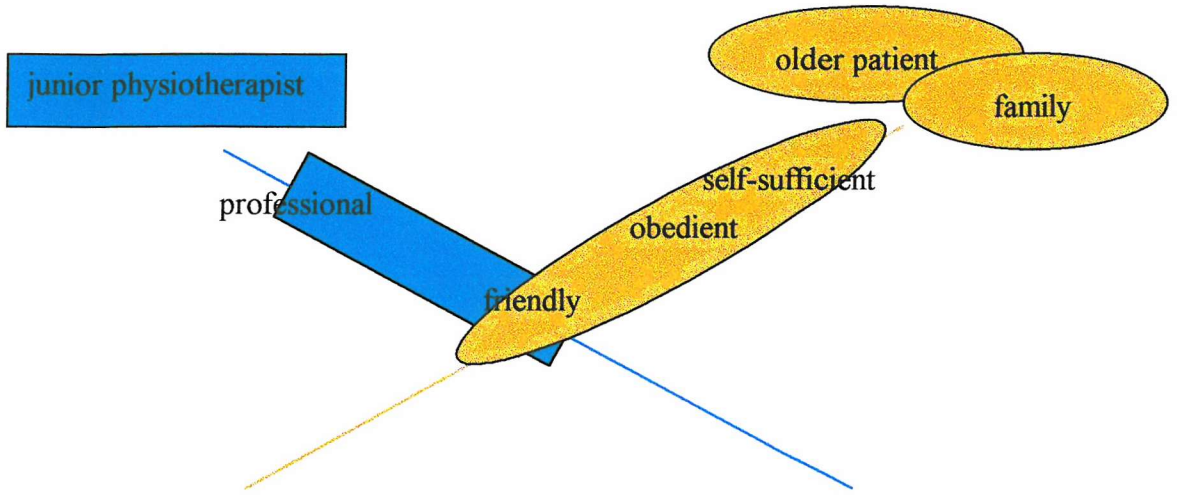
The relationship described by the older patient and his family and observed during the treatment encounter fluctuated from total patient/family self sufficiency to a friendly relationship. This self-sufficiency was demonstrated through excluding the physiotherapist from family jokes and home issues and showing a determination to achieve what the physiotherapist described as unrealistic goals. In contrast obedience was shown by a willingness to comply with all exercises without question. A friendly relationship was characterised by the participants' friendly demeanour, some expectation from the older patient of self-disclosure from the physiotherapist and use of humorous banter by the older patient. The attribution of "friend" was not considered appropriate by the older patient. Interestingly the patient described the term "professional" as pertaining to his interpretation of the physiotherapist/patient roles.

"Well, I can't actually call her a friend of mine because we've got a sort of professional relationship... but I wouldn't ignore her if I saw her out." (Case 4, Older patient, 167-173 edited)

This patient's interpretation of the concept of 'friend' was further reinforced by the reaction of the family to the arrival of two people described by the older patient as friends on two of the three occasions I visited him. These people were greeted in the same way as the physiotherapist and myself but were immediately expected to assist with household tasks (adjusting the central heating thermostat, moving some furniture upstairs to enable access for the older patient's wheelchair). They were also offered a cup of tea. Neither of these were expected of nor offered to the physiotherapist or myself on any of the occasions I met with the family.

The range of levels of engagement within this relationship as described by the participants is illustrated in figure 6.6.

Figure 6.6 The case 4 junior physiotherapist/older patient relationship as described by both participants



In summary, this relationship was the most complex of the three cases as the patient's family was so closely involved. The physiotherapist described her relationship as varying between professional and friendly depending on her intuition as to which role would best facilitate good communication and engagement with treatment. Her role choice was also dependent on the role taken by the patient at any one time. This ranged from self-sufficiency through obedience to friendly and appeared to depend on levels of family involvement and distraction. It is not possible to judge the effect of changing venue on role as the encounter took place entirely in the patient's own home. There was no appreciable role change at the commencement and end of the treatment session.

6.3.3 Emerging Roles

This study has confirmed the findings of the previous two studies that roles are important in the relationships arising from the physiotherapy clinician/older patient encounter.

These include the role of the relationship itself and the roles of the participants. These sit alongside the notions of partnership and professional power.

The Role of the Relationship:

Firstly, it is apparent that the relationship itself has a role to aid clinician/patient communication. This enables the clinician to show their professional and human sides facilitating the development of trust as a precursor to engendering adherence to treatment. Patient/clinician communication is also facilitated by a good relationship making the patient more comfortable about sharing the personal information that will assist in goal setting. All parties believe that a good relationship enhances clinical outcome and satisfaction for both.

The Roles of the Participants:

In addition, both clinician and older patient have roles within the encounter. The previous section outlines the participants' levels of engagement within the relationship and show how they vary within the same relationship depending on which role is being played out by each participant. Although levels of engagement ranging from technician to personal relationship were identified from the larger sample of physiotherapy clinicians interviewed in the first study this third study seemed to show two main roles, professional and befriender.

The professional role is used to establish the clinical right of the physiotherapy clinician to treat the patient. It determines the specialist, technical knowledge, clinical skill and experience of the clinician. The knowledge that the physiotherapy clinician is a recognised medical expert engenders trust and respect for that expertise.

"You've got to do it sort of thing, you know. Which is quite alright really. She knows what she's talking about." (Case 3, older patient, 420-424)

The professional role does not, of itself, make for a good relationship. The older patients in this study apply this professional status equally to both qualified physiotherapists and

assistants. Where older patients describe bad relationships the fault is seen to lie in the human element of the relationship or in problems with the service delivery. The professional expertise of the clinician is rarely called into doubt.

The other main role adopted by the physiotherapist is that of befriender. This role draws on the human elements of the clinician and is recognised by older patients as the human face of the professional. Clinicians use it to encourage their patients to share personal information in clinical assessment to identify mutually appropriate goals. They also use it to reassure patients in new, painful or challenging clinical situations. Many have learned that their patients like them to disclose some personal (but not private) information. This reinforces their human side and enables the patient to see them as not just empathetic but also as having experienced similar life events within their own families. Private information is not shared as this is felt to exceed professional boundaries and be a possible embarrassment to themselves and their patients.

The definition of befriender – "one who makes a friend of" (Collins English Dictionary, 1981), varies between physiotherapy clinicians. It varies from being friendly – "having the disposition of a friend, kind, favourable" (ibid) to being a friend – "one well known to another, regarded with affection, intimate associate, supporter" (ibid). The word befriender implies some active effort on the part of the befriending individual and this was present in those physiotherapy clinicians considering they had friendly relationships with their older patients.

"When I walk through the hospital and they're in there, ones that I've treated at odd times and I always make sure I say hello to them and Good Morning and I'll stop and ask how they are." (Case 2, Physiotherapy assistant, 326-329)

"With a very reserved patient you try and crack them a little bit by being, you know, friendly and trying to get them to open up." (Case 1, senior physiotherapist, 451-453)

The older patients reciprocated the personable approach of the physiotherapy clinicians and were eager to be seen as appreciative of their treatment. However, they appeared to adopt traditional patient roles demonstrating passivity, obedience and gratitude.

"You want to please them because they're doing their best to help you, aren't they." (Case 3, older patient, 308-309)

Even when one patient did not understand the purpose of treatment he did not challenge the physiotherapists or ask for a treatment he felt more appropriate. This quote demonstrates his passivity and frustration and the lack of communication between therapists and this patient.

"I've done several sessions on this stand up sit down machine but there was no target in me doing it, I was just doing it because they wanted to try the machine out, that's all, to my way of thinking. I was just a guinea pig on a machine." (Case 4, older patient, 72-76)

The Notion of Partnership:

The topic of partnership has arisen through this research. The physiotherapy clinicians strive towards it and feel they achieve it, whilst the older patients mostly do not perceive it to be present or important. This was reiterated in these individual cases. The current NHS push towards partnership with patients (DOH, 1999) encourages patients and public to have a greater role in the care they receive (Mead, 2000). Physiotherapists interpret this as aiming for an equality of decision-making in goal setting. In case 4, when asked whether she felt she had a partnership with the older patient, the physiotherapist replied:

"Yes, I'd like to think so in terms of we've both got... we've all got goals that we're aiming for, be it their goals are slightly different to what I have in mind. I've tried to keep it - the goals that we've set, you know, we've set them together and this is, you know "I know this is what you want to achieve but let's aim for this first"". (Case 4, physiotherapist, 518-522)

This physiotherapist felt that the partnership was not automatic rather it was negotiated. In this encounter it appeared that the physiotherapist had initiated the partnership and that negotiations continued as the encounter proceeded.

The older patient in this case clearly felt that goal or "target" setting was an appropriate feature of his treatment. However, his feeling that targets should be prescribed by a senior clinician from a standardised manual for stroke treatment underlines the disparate understandings of patient and physiotherapist and the workings of the health service.

"Well I think that someone perhaps higher up should sort of work out the targets. That's [making a quiche] the first target I've had. That's something that we worked out between us, but I thought it would be set down somewhere on paper and in a folder like you've got there - a target for stroke victims to get them working again, you know, all laid down in black and white." (Case 4, older patient, 249-274 edited)

Another patient observed in this study felt that partnership did not mean equality of status, rather an equality of participation. He felt that he was bringing the determination and the will to get better whilst the physiotherapy clinicians were bringing the clinical expertise and encouragement. He felt that this made him more comfortable in a treatment situation.

"If I went there and I didn't have that partnership, if I got embarrassed, like you say if I take me clothes off, I'd be embarrassed if I didn't have that partnership, probably. But I'm not worried about it, it don't worry me." (Case 1, older patient, 302-305)

The older patient in case 2 was uncertain as to whether she had or wanted a partnership with her physiotherapy clinicians. It is not even clear whether she understood the term. Her passive, obedient role is apparent from this section of the interview. (I – interviewer, P – participant).

"I: Do you feel you have a partnership with her? (pause)... Do you feel you bring anything to the treatment?

P: I may do. (pause)

I: Or is it just her who says "we're going to do this"?

P: (pause) ...I may bring, you know... difficult to say really. (pause) Well I... I'm like this. If I think [the physiotherapist]'s not there I look all disappointed and then she comes and then I beam all over, you know." (Case 2, Older patient, 289-300)

In case 3, the senior physiotherapist described her relationship with the older patient as a "working partnership" although the patient did not recognise this, describing a much more obedient, unquestioning role.

"I: When you are doing your exercises, does [the physiotherapist] tell you what to do or does she talk to you about the different possibilities and you make the decision about what to do and how to do it?

P: No, she says "Oh we'll go over onto here now and do this and do that". She explains why she's asking you to do it, sort of thing, you know." (Case 3, older patient, 449-455)

The Notion of Professional Power:

Professional power underpins the physiotherapy clinician / older patient relationship. The older patients in this study all expected it and this example illustrates how it informed one patient's passivity in the encounter.

"It [patient/physiotherapist hierarchy] don't worry me. They know what's good for me... Yeah, whatever they want I do, cos it's for my benefit." (Case 1, older patient, 412-415)

In another case the physiotherapist identified the link between her professional role and the professional hierarchy that existed between her and the older patient suggesting that clinical knowledge was the causative factor.

"Very definitely the patient looks up to the person with the knowledge and says, "What do you think?" (Case 4, physiotherapist, 556-557)

From these cases it would appear that these older patients are very responsive to the physiotherapy clinicians' approach often mirroring their friendly tactics in order to denote their recognition of expertise and willingness to submit to the clinicians' clinical skill. This mirroring is apparent in their obedience to the clinician's professional role (case 2) and through a mutual sharing of humour with the befriender physiotherapy assistant (case 1).

6.4 The Physiotherapy Clinician / Older Patient Relationship: A Model for Partnership or the Potential for Conflict?

The physiotherapy clinician/older patient relationship is a finely balanced juxtaposition of roles running alongside the clinical intervention. Older patients expect physiotherapy clinicians to present in a professional role and therefore present themselves in what they believe to be the appropriately passive, patient role, obedient and complaint to the clinicians' professional expertise. This relationship may be described as one of teacher/pupil although the traditional age difference between these roles is reversed. Physiotherapy clinicians recognise that although this professional role has benefits of being seen as the expert in treatment planning, goal setting and discharge planning, the more relaxed human approach of befriender encourages the older patient to open up, divulging the personal information required for in depth assessment and engendering a willingness to please through adherence to treatment programmes. The patient responds to this professional approach with obedience and to the befriender role with self-disclosure, and often, humour. Current practice guidelines dictate that physiotherapy clinicians seek partnership with their patients. Older patients have little concept of or need for this role appearing to be reluctant partners in their treatment preferring a less demanding and more familiar role within this hierarchical situation. Little role conflict between the patients' roles of passive patient and reluctant partner was identified although there was a level of misunderstanding and bewilderment in the differing expectations that the physiotherapy clinicians had of them.

Case 1: This patient saw partnership as him having the determination and the will to get better with the physiotherapy clinicians providing the expertise and the encouragement. He wanted all the clinical decisions to be made by the physiotherapists and did not understand why he need be involved in any negotiated partnership.

Case 2: This patient described the physiotherapist sitting down with her and asking her what she wanted from the treatment. She had not considered anything less than full recovery and could not conceive having any useful input in an area where she felt she had no expertise. She was entirely happy in her passive, obedient role. However, her daughter had written complaining that her mother was not having enough treatment and the patient, whilst passive in her patient role during treatment, was active in asserting that this should happen.

Case 3: This patient saw partnership as the physiotherapist explaining the reasons for her treatment. She did not question her even although she remained unclear about several aspects of her treatment. She felt able to question the physiotherapist if she wanted to but did not feel it was her place to do this. The implication was that if she was supposed to know, the physiotherapist would make it clear.

Case 4: This patient saw partnership as working towards agreed goals. However, rather than goal negotiation he felt his role should be to agree to a prescribed target chosen from a list predetermined by experts in stroke rehabilitation. He felt he had a working relationship with his physiotherapist but would not consider challenging her decisions or asking why he was doing a particular exercise, feeling that this was privileged professional information from which he was excluded. He saw no reason to challenge this.

In contrast there is considerable potential for role conflict for the physiotherapy clinicians who, often unwittingly, moved between directive professional and inclusive befriender roles. This potential for conflict was managed in different ways by the clinicians observed in these cases.

Case 1: Here the senior physiotherapist and physiotherapy assistant had a longstanding working relationship and their roles were well defined within it. The senior physiotherapist managed the potential for role conflict by taking the professional role whilst encouraging the physiotherapy assistant to befriend the older patient. They blatantly played self confessed "good cop, bad cop" roles to separate the use of strict professional expertise within a defined hierarchy to keep the treatment programme on track and a more friendly approach used with humour to ensure continued encouragement and compliance. Although this approach could be seen as excessive use of professional power, manipulative and coercive, the clinicians saw no issue with working this way, feeling that it was the most efficient use of clinical resources. Partnership was assumed as goals were felt to be set in agreement with the patient and his family.

Case 2: In this case the senior physiotherapist had reflected deeply on her understanding of partnership. She appreciated that she had two roles in the relationship. She saw her professional role as a responsibility to be honest with the patient and never to assume that her treatment goals might be those of the patient. She also appreciated that she needed to gain the patient's trust through a friendly disposition and use this to encourage adherence to treatment. She described defining her professional role clearly from the start of the encounter and reiterating it throughout the episode of care to reduce the potential for disappointment should this patient be discharged before achieving full recovery as seemed increasingly likely. Her concern was with the patient's reluctance to engage in a working partnership that the physiotherapist felt she should work towards.

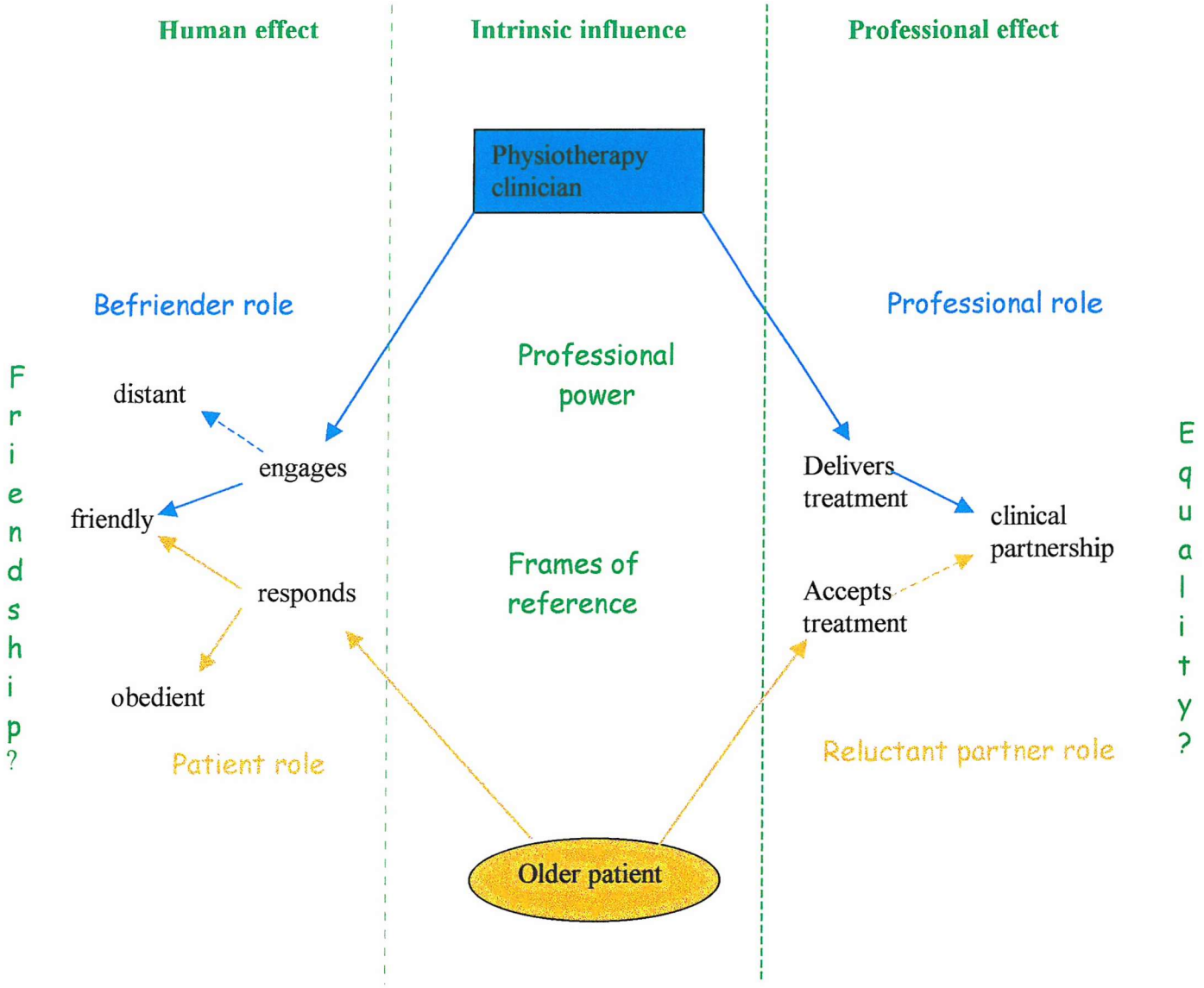
Case 3: The strict professional approach of the senior physiotherapist appeared to show only one role for this clinician therefore limiting the potential for conflict. Given that the befriender role appears to be important in information gathering and encouragement it could be construed that these were missing from this encounter. However, the way in which the senior physiotherapist manages this service provides these factors. Patients are fully assessed by nursing staff in the day hospital and the physiotherapist has access to their notes and does not need to befriend the patient to glean this information. The

patients are treated together in the gym and provide mutual encouragement for each other.

Case 4: This complex case identified several actual conflicts, none of which were being managed. The junior physiotherapist found herself torn between seeing herself as a professional and one of the patient's family. She tried to manage some separation by being directive during treatment and refusing to be drawn into old discussions about unachievable goals. However, it was apparent that the family had different expectations to those of other health care professionals and the physiotherapist felt that she had to remain a befriender in order to keep the lines of communication open where others had closed. She was also trying to manage another conflict that she had been drawn into, finding herself having to mediate between her more experienced senior colleague and the patient with whom the senior had a poor relationship. As a newly qualified and inexperienced physiotherapist she was trying to champion the needs of her patient, defend her senior to the patient and his family and maintain her good relationships with the senior physiotherapist vital for her professional progression. This case identifies another role of the befriender, that of champion for the older patient where communications are poor between older patient and other health and social care agencies.

The findings from these cases builds on the findings of the other two studies. They suggest that physiotherapy clinicians and older patients play different roles in the relationship that develop between them alongside and because of the therapeutic encounter. These roles are socially determined and sit within the professional hierarchy and models of health service delivery prevailing in organised health care. A model describing the juxtaposition and relationship of these roles is set out in figure 6.7. The roles and their implications in the delivery of physiotherapy services for older people are discussed in the next chapter.

Figure 6.7 The physiotherapy clinician/older patient relationship: a role model



Blue denotes physiotherapy clinician thread

Orange denotes older patient thread

Green denotes concepts

This model (fig 6.7) describes the roles of the physiotherapy clinician and older patient within the relationship. As identified in the earlier studies, the relationship is inextricably

entwined within the physiotherapy encounter. This encounter comprises human effects, professional effects and intrinsic influences (Figure 4.4). This model describes how both physiotherapy clinician and older patient respond within the human and professional elements of the encounter, both of which are moderated by intrinsic influences.

Physiotherapy clinicians demonstrate their professional role through the delivery of clinical expertise, aiming to achieve optimum outcome by encouraging clinical partnership with their older patients. They also demonstrate their human side by engaging with the older patient in order to promote rapport for information exchange, encourage trust and optimise patient engagement with their treatment. Although some physiotherapy clinicians (denoted by a dotted line) prefer to retain a distant, professional rapport to prevent over familiarity and the possibility of patient dependency or to prevent compromising the relationship if bad news has to be given, most report taking a friendly approach in a befriender role.

The intrinsic influence of professional power defines the hierarchy that separates the knowledgeable physiotherapy clinician and the uninformed patient for whom rehabilitation may be a new experience. Both parties bring their past knowledge, experiences and beliefs (frame of reference) to the encounter. This includes the model of health delivery employed by the physiotherapy clinician which is defined by their beliefs and the philosophy of the service within which they work. These intrinsic influences inform the ways in which the physiotherapy clinicians and older patients interact at human and professional levels.

The older patient is very aware and accepting of this professional hierarchy and responds at a human level in a traditional patient or sick role, eager to be seen to place themselves into the hands of professional expertise and obey instructions, many without questioning. Whilst some older patients report responding with a more distant obedience in line with their beliefs about their patient role, many respond in a friendly manner, seen as showing normal human engagement or demonstrating a willingness to co-operate, or which may simply mirror the physiotherapy clinician's friendly approach. The friendly relationship

engaged with by both parties is discussed in the next chapter within the concept of friendship.

The reason for the encounter is the physiotherapy treatment of the older patient. The older patients in this research accepted the treatment offered with little if any understanding of the clinical partnership that physiotherapy clinicians felt they were achieving. Most felt little need for clinical partnership, preferring to leave treatment choices and goal setting to the clinicians who were perceived to be the experts. Thus they took a reluctant partner role within the professional element of the encounter (denoted by a dotted line). The discrepancy between the physiotherapy clinicians and older patients' perceptions of being clinical partners is discussed in the next chapter within the concept of equality and the National Health Service's perceptions of partnership.

6.5 Reflecting on this Study

Being a participant observer opens the researcher to the potential criticisms of bias both in the undoubted influence their presence has on the situation being observed and in their interpretation (Angrosino and Mays de Pérez, 2000). The ways in which these potential biases were addressed are discussed in the methodology chapter (3.5) and the implications in the specific cases under scrutiny in this research are discussed here. It is intended that through clear literal, interpretive and reflexive recording and thought (Mason, 1996: 69) the findings in this chapter are a trustworthy interpretation of the experience.

The participating physiotherapists had been asked not to introduce me to the older patients as a physiotherapist but as a researcher. This was done with no intent to deceive but purely to enable the patient and myself to concentrate on the reason for my observation and subsequent interview – research rather than treatment. I did not want to become engaged in clinical conversations that were inappropriate, time wasting and potentially damaging to the patient's treatment programme.

However the treating physiotherapy clinicians all knew of my professional background because of their own links with the School of Health Professions and Rehabilitation Sciences. Most of them had supervised undergraduate students and several had assisted in teaching at the School. I had also worked with some of them in the past. The physiotherapy profession is a small world and, as a chartered physiotherapist, it would be almost impossible to conduct research in a unit where you were entirely unknown. This undoubtedly impacted on my own relationships with some, if not all of the physiotherapy clinician participants.

The case one participants had met with me on several occasions and had identified one of the older patient participants for the older patients' perspectives study. The physiotherapy assistant had taken part in the physiotherapy clinicians' perspectives study. Although the physiotherapy assistant had expressed a concern in the earlier interview that her views would be of little value, I feel that our subsequent discussions in that interview and when arranging case one actually gave her the confidence to be more open in the final interview. Similarly, the senior physiotherapist is a confident person and had no qualms in telling me of her professional practices that could be conceived by some as stretching professional guidelines. The impact of my presence on the older patient in this case is more difficult to judge. Certainly he appeared to speak freely but he did not make any negative comments about the physiotherapists or his physiotherapy even although they described times when they had reprimanded him for non-compliant behaviour. Similarly, it is impossible to judge what impact my presence made on the treatment observed. Certainly everyone else was excluded from the treatment gym during this session and I was told this was *"usually the case"*. I was studiously ignored by all parties during this session apart from being offered a cup if tea at the end.

In case two I feel that the hierarchy between researcher and physiotherapy clinicians was more overt. Not only had I taught the senior physiotherapist as an undergraduate but I had also supervised her undergraduate research and collaborated with her in a subsequent research project. Ideally I would have excluded her from this research but chance dictated that she was the only potential participant in this department because of staff

rotations. Before asking her to agree to take part in this project we discussed (on neutral ground) the implications of her participation on us both and on the research and agreed that, although we could not change our circumstances we would acknowledge their potential effect. This was reflected in a very honest and open interview. The physiotherapy assistant in this case and I did not know each other before the case commenced. This assistant appeared to have a strong sense of organisational hierarchy and, I feel, saw me as part of that. This sense of hierarchy was clear when she asked for a statement written on university letterhead saying that she had taken part in research to add to her NVQ portfolio. She appeared happy to discuss personal experiences and feelings in the interview and did not appear inhibited. The older patient in this case appeared to respond to me in the same obedient way as she did to the physiotherapy clinicians. Even when interviewed at home she did not demonstrate any different characteristics. This behaviour may have been her natural demeanour, it may have been her usual response to physiotherapists and researchers or it may be that, having lost her independence and being reliant on family, carers and therapists for her basic needs (including a place to live) she found that this role made life the easiest for her. It is not possible for me to judge. During the treatment observation I was one of many other people sitting in the department – others were treating other patients or writing notes. All participants said in the interviews that this treatment session had not differed from any other. Certainly no one made any verbal or visual reference to my presence throughout the session but again I cannot truly judge this.

The senior physiotherapist in case 3 and I had worked together in the same hospital eighteen years previously but did not have any social relationship. It was apparent from her responses to me throughout this research project (being interviewed in the physiotherapy clinicians' perspectives study, accessing older patients for the older patients' perspectives study and taking part in this case) that she was rather in awe of my role. She was very happy to assist but seemed rather nervous. I actively tried to alleviate her anxieties by dropping into the department at coffee times and getting to know her and the other therapy and day hospital staff on a less formal basis. I am not sure that I succeeded. My presence at the treatment session clearly influenced the situation. The

physiotherapist frequently spoke to the patient in a way that informed me that she was giving this patient an appropriate treatment, as indicated in the field notes reflection (143-152).

"During the observed session [older patient] appeared to be getting the lion's share of the treatment, [senior physiotherapist] spending on average three times longer with her than each of the other individuals [patients in the gym]. This was probably the influence of my presence. She also made several comments relating to [older patient's] treatment and progress (directed separately to [older patient] and myself. These related to the appropriateness and success of her treatment e.g. to [older patient] *"I'm not going to be able to persuade you to wear flat shoes am I?"* and *"You should have seen [older patient] when she first came for treatment. She has improved so much."*

Case four was a difficult case for me to approach objectively. The complex family involvement, the differing relationships identified (both good and bad), my professional concerns that perhaps this patient was not receiving the best advice and the physiotherapist was not receiving appropriate supervision all combined to impact on my interpretation and analysis. As in the previous case I was drawn into the treatment observation, but this time by the older patient rather than the physiotherapist. It was easy to deflect this attention but my presence was undoubtedly a distraction. However, this household was continually fluctuating as people came and went and it is probable that my impact had no different influence. The knowledge that I was a fellow professional may have dictated the physiotherapist's careful choice of words when describing her relationship with her senior. This would have been judicious regardless of who had been interviewing, however, the impact of actually voicing these views that may have remained unspoken had the interview not taken place is unknown but needs to be acknowledged. To prevent inappropriate bias I have had to reflect very carefully on observation data that I collected, the questions I asked at interview and my interpretations of the data. I tried to limit any overt bias at the time and have excluded any noted later, but the influence of my professional background cannot be denied.

These cases have been a useful learning opportunity to experience another data collection method and use findings from that to inform more specific interview questions. Reflecting on my impact as researcher and physiotherapist on this type of research has given considerable insight into the role of the participant observer.

6.6 Summary

The exploration of the physiotherapy clinician/older patient relationship continued with the observation of individual treatment sessions followed by interviews with the older patients and the treating physiotherapy clinicians. The role, rationale and constituents of the relationship identified in the previous two studies were also found in the individual cases confirming Models 1 and 2. Each individual case was considered alongside the levels of engagement model (fig 5.3). Physiotherapy clinicians identified two main roles that they took within the relationship, professional and befriender. Older patients mostly responded in a friendly fashion, happily assuming a compliant stance. Physiotherapists, however, also wanted them to become partners in their care. Older patients were reluctant partners and felt more comfortable in the patient role within the clinical hierarchy. The participant researcher role requires insight into the impact of the researcher on the interviewees and the area under observation. It is considered that the role of the researcher as a clinician, ex-tutor and ex-colleague will have influenced the data and interpretation. The "Role Model", including the roles and concepts, is discussed in the next chapter.

Chapter 7

The Physiotherapy Clinician/Older Patient Relationship: a discussion

7. Introduction

The chapter discusses the concept of the therapeutic relationship and how it relates to the physiotherapy / older patient encounter in older person's rehabilitation. The findings of the three studies undertaken in this research are reiterated and explored in the light of the aims of the research. Early findings recounting the role of the relationship within the therapeutic encounter, its rationale and components are related to the literature on forming relationships in general and therapeutic relationships in particular. The key concept of role as outlined in the "role model" (fig 6.7) is discussed, specifically the dual roles of professional and befriender adopted by the physiotherapy clinician as well as the traditional sick role of the older patient and the way in which clinicians draw them into a reluctant partner role. Each of these roles is underpinned and influenced by a broader concept. The professional role is greatly influenced by professional power, the befriender role by the participants' perception of friendship, the sick role by the prevailing models of health care and the reluctant partner role by the NHS move to clinical partnership. These are considered in the light of NHS service culture and social theory. Finally the role conflicts present at individual levels within the physiotherapeutic dyad are discussed in relation to the broader contradiction between professional hierarchy and the movement towards equality in health service policy. New literature searches relating to these topics were undertaken and the relevant literature is introduced, discussed and critiqued in the light of this research.

This chapter concludes with a critique of the use of grounded theory methodology as an NHS physiotherapy research tool.

7.1 Unpicking the physiotherapy clinician/older patient relationship

The therapeutic relationship has been severally defined as "a means of communication wherein both therapist and patient interact to achieve a therapeutic goal" (Gartland, 1984), "an effective and mutually satisfying medical encounter" (Greene et al, 1994) and

"that special relationship between the person seeking help or healing and the healing from whom it is sought... a deeply powerful agent for change" (Hagedorn, 1995:108).

The relationship under exploration in this research is that between physiotherapy clinicians (Qualified chartered physiotherapists and physiotherapy assistants) and their older patients receiving medium to long-term physiotherapy rehabilitation in outpatient day hospital and domiciliary settings. Here, treatment is usually geared to the management of disability relating to profound or multiple disabilities and, as such, demands a holistic management rather than a curative, impairment driven approach.

It has become clear from this research that the term therapeutic relationship is not entirely accurate in this setting in that, whilst it is a relationship that develops within a therapeutic encounter, it is not deemed (by the participants in this study) to be therapeutic in its own right, as it would be in a psychotherapy encounter. Following the study of physiotherapy clinicians the use of this term was changed to 'physiotherapy clinician/older patient relationship' to reflect the cohorts under investigation. A more general term encapsulating the non age specific physiotherapy clinician/patient relationship would be 'physiotherapy encounter relationship'. Certainly, both parties feel such a relationship exists. The term relationship implies dyadic participation, which is the case in this research.

This relationship exists alongside the physiotherapy intervention within the encounter (Model 1 figs 4.3 and 4.4). Unlike many social or family relationships, it only exists because of the encounter. Gartland (1984), Sim (1986), Kumlin and Kroksmark (1992), Miller et al (1996) and Williams and Harrison (1999) all describe the physiotherapy/patient relationship as a therapeutic relationship although none define why they call it such. It is not known whether their definitions would site the relationship within the encounter alongside the clinical intervention and healing. Within the physiotherapy clinicians' study findings few encounters comprising only a relationship and healing were described. These occur where intervention is absent or secondary

within the encounter and were considered to have placebo effect only (Dixon and Sweeney, 2000).

This research found the relationship to be an important and integral part of the physiotherapy encounter in the medium to long-term rehabilitation of older people. The use of the term "physiotherapy encounter" reflects this and also alludes to the therapeutic impact of the encounter through the use of the word "physiotherapy". The relationship cannot be described in isolation and both it and the intervention are considered to impact on, and be influenced by, clinical outcome.

The relationship develops from both parties. It is felt to ease a new and possibly difficult situation for the older person. The older patients respect the physiotherapy clinicians' expertise and time and generally do not want to be seen to abuse that. Initially they may mirror the physiotherapy clinician's professional or friendly approach in order to demonstrate their willingness to comply with treatment.

The relationship may also be used by the physiotherapy clinician to reduce the perception of inherent clinical hierarchy, optimise communication and information exchange and develop the potential for clinical partnership. It also has the potential to encourage compliance and adherence to physiotherapy through the development of trust. A good relationship appears to increase the satisfaction of both parties.

The relationship has components (professional, human and intrinsic) brought to it by both parties and the service, including local and institutional effects (Model 2, appendix 7.1). The juxtaposition and use of these components dictate whether the relationship is perceived as good, bad or non-existent.

The intrinsic, professional and human elements arising from these findings relate to the thinking of Fadlon and Werner (1999) who describe the micro and macro sociology of the healthcare professional / patient relationship. They define this micro sociology as an

understanding of the mechanisms that construct situations including symbolic interaction, verbal exchanges and perceptions of role and status.

These mechanisms were apparent in the physiotherapy clinicians' and older patients' understanding of the therapeutic relationship as interaction, interpersonal skills and hierarchy. Caney (1983) suggests that a competent physiotherapist should acquire and integrate three key skills: cognitive, practical/technical and social. This concurs with the findings of this study where physiotherapy clinicians considered a good relationship to have personal components based on their clinical reasoning skills (cognitive skills), clinical competency (practical/technical skills) and an ability to communicate and empathise (social skills).

Wagstaff (1982) identifies the importance of communication as a means of persuasion. Klaber Moffett and Richardson (1997) consider communication an important factor in the physiotherapist-patient relationship although this is more related to explanation and patient education. From their research with patients with chronic back pain, they consider that the physiotherapist has the opportunity to build a rapport with the patient that enables them to affect the patient's attitudes and behaviour. This rapport was certainly considered important by the participants in this study especially with long term, multi-pathology patients requiring sympathetic professional advice to adapt their lifestyle to new or increased disability. Klaber Moffett and Richardson take this one stage further suggesting that the careful management of this relationship allowed the patient to take control of their own problems. This model shares common factors with the psychotherapy approach of transference (Denes, 1980; Niolan, 1999). Physiotherapy clinician participants in this study did not identify with this approach possibly because of the different client group and difference in presenting pathologies. However, they did appear to take prior healthcare and illness experiences of their patients into account when describing their engagement in the relationship. They felt, as van Rooijen (1993), that such experience would influence the patient's behaviour and engagement in the intervention and relationship.

Argyle (1994) states that people construct their impression of others based on three factors; role, including class, occupation and perceived status; presentation of self to others including physical characteristics of height, attractiveness and clothing, and personality traits including intelligence. In social settings people use their perceptions of others to make choices about the relationships they form (Argyle, 1994). In the physiotherapy clinician / older patient encounter there is little choice as to whether the episode of physiotherapy care takes place. It has already been established that a relationship develops because of the intervention, but although the physiotherapy clinician has made an active choice to enter this profession, they are then required to relate to patients to whom they may not have chosen to relate in social encounters. In physiotherapy disciplines such as sports injuries, the patient will usually approach the physiotherapist for treatment. However, in older persons' medicine, the patient is often referred for physiotherapy treatment as part of a package of care determined by the multidisciplinary team. Both physiotherapy clinician and older patient participants described situations where the patient had no idea that physiotherapy treatment had been prescribed and expressed surprise when the physiotherapist arrived to see them. This must impact on the potential for partnership equality within the relationship as it reinforces the clinician / older patient hierarchy.

Carl Rogers had the strong conviction that "the therapeutic relationship is only a special instance of inter-personal relationships in general, and the same lawfulness governs all such relationships" (Rogers, 1964: 306). Although relationships do appear to have similar constructs in that they are an "act of acquiring, using and maintaining mutual knowledge, creating an ongoing process that becomes increasingly sophisticated and complex the better we know somebody" (Duck, 1994: xii), it is apparent that relationships between clinicians and patients differ in emphasis. The participants here are not trying to make friends but have the goal of conducting some clinical transaction while the situation is both defined and constrained by clear rules and conventions (Argyle, 1994). Goals in a social situation refer to social acceptance and task goals specific to the situation. In social situations conflicting task goals may compromise the social goal of keeping on good terms with the other person (Argyle, Furnham and Graham, 1981). This

is apparent in physiotherapy clinician / older patient relationships where treatment goals conflict. Some physiotherapy clinicians noted situations where the relationship between them and their older patients was poor. Clearly, poor communication, inappropriate choice of patient goals and lack of empathy could adversely affect the more basic interpersonal relationship between physiotherapy clinician and older patient. Given the power dynamics of the relationship it is perhaps the responsibility of the clinician to address this problem rather than blame the patient, reduce their intervention or hand them on to another therapist.

Self-disclosure, defined as "what individuals verbally reveal about themselves to others, including their thoughts, feelings and experiences" (Derlega, Metts, Petronia and Margulis, 1993), appears to be an important component in the physiotherapy clinician / older patient relationship. Archer (1979) found that self-disclosure varied with sex, age, race, religion, birth order and socio-cultural differences. Self-disclosure leads to liking which in turn leads to further disclosure. Collins and Millar (1993) suggest that we like one another as a result of having disclosed. Critical elements for facilitating disclosure include developing a trusting relationship with the patient and listening very carefully to cues that may be veiled disclosures (Limandri, 1989). Most physiotherapy clinicians interviewed appear to have a well developed ability for self disclosure although in qualified clinicians this was skilfully employed to share just enough of themselves to facilitate reciprocity from the patient whilst withholding personal information that they perceived would have transgressed their personal and professional boundaries.

This micro view needs to be set into a macro context. Macro sociology relating to the healthcare professional / patient relationship describes the broader social and cultural context including "interpretive and behavioural repertoires to which participants have recourse" (Fadlon and Werner 1999:197).

Bloom (1963) states that the therapeutic relationship cannot occur in a vacuum but takes place within the wider social and cultural matrix. Within this matrix, factors owned by the physiotherapist and physiotherapy assistant include their personal philosophy,

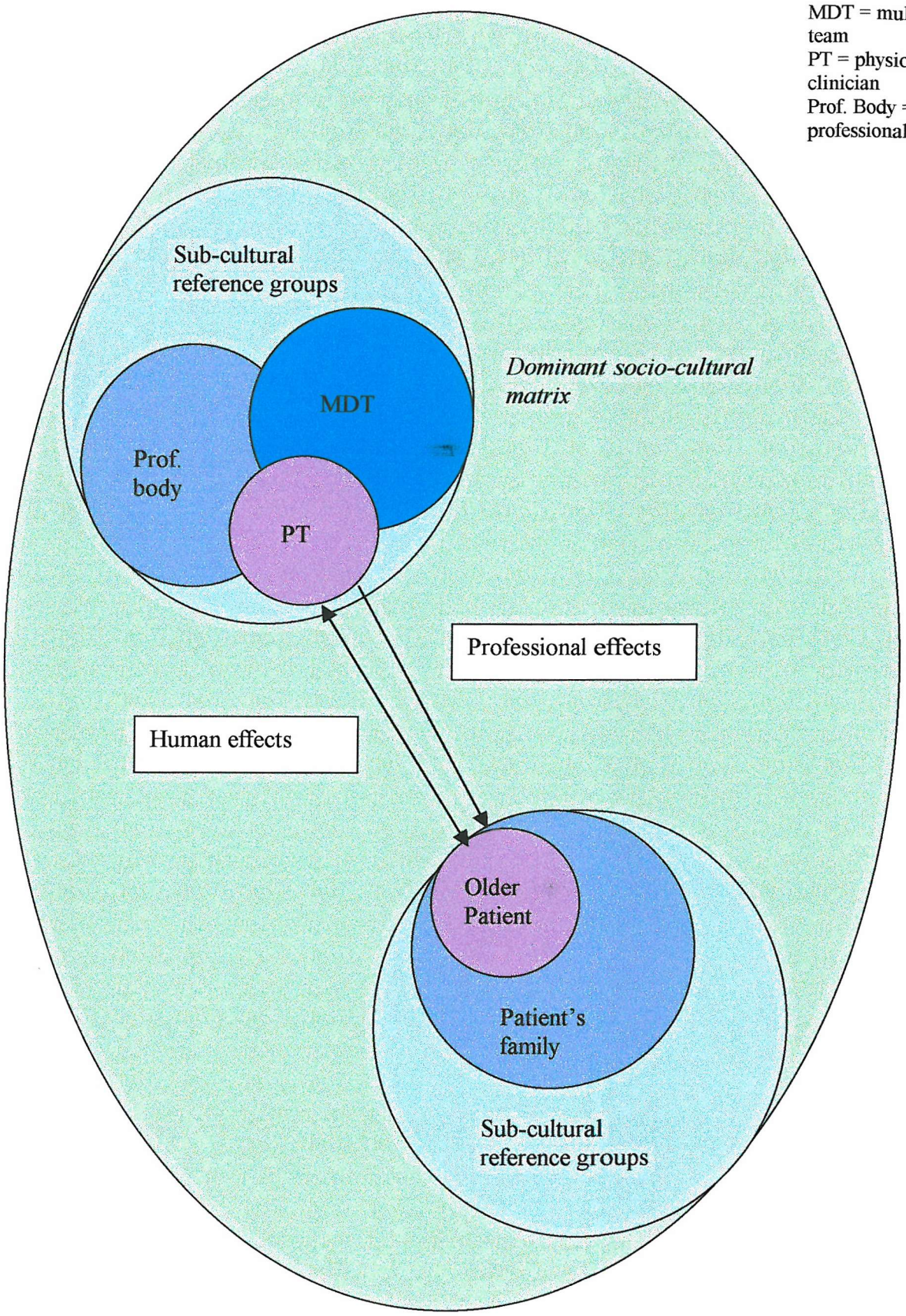
socialisation, beliefs and attitudes. Patient factors that impact on both the intervention and relationship include past health and life experiences and beliefs. Factors that affect both include socialisation and the environment in which the encounter occurs.

Within this matrix the physiotherapist is not a free agent in the relationship, being influenced by the wider role and aims of the multi-disciplinary team (MDT) and the codes of conduct and practice of the professional body. The older patient is similarly influenced by their family, friends and any carers involved in their recovery. Each clinical encounter takes place within a given social and cultural context. In the UK National Health Service this has to be seen within the re-organisational changes and the implementation of the National Service Framework for Older People (DoH, 2001a). This social and cultural context dictates the relative status of the physiotherapy clinician and older patient in society and this in turn will inform the behaviour of both parties. Bloom (1963) suggests that both patient and clinician will change their behaviour during the professional encounter depending on the social context.

Alongside the dominant social and cultural system a set of sub-cultures exist (Bloom and Summey, 1978). These are constructed around ethnic origin, socio-economic status and religious and cultural beliefs all of which are considered to influence health beliefs and health behaviour (Fadlon and Werner, 1999). This acknowledges that, although physiotherapy clinician and older patient belong to the same society, they may not belong to the same sub-culture, a situation that can cause problems with communication and approach. This is evident from the physiotherapy clinician participants' need to empathise with the lifestyle and beliefs of the older patient in order to facilitate engagement with both the intervention and the relationship.

Bloom's model is set on a horizontal axis (1963). This has been adapted using the findings of this study in figure 7.1. This model is set at a slant with the physiotherapy clinicians appearing higher than the older patient. This represents the professional power that dictates a hierarchy between clinicians and patient. However, the clinician's

Figure 7.1 A Model of the physiotherapy clinician /older person relationship from the broader socio-cultural perspective. Adapted from Bloom (1963).



perception of the move towards some kind of clinical partnership shifts the model from a true vertical alignment to the slant as shown.

Within Bloom's adapted model, this research has shown that the participants in the physiotherapy clinician/older patient relationship also engage at different levels, as demonstrated in Model 3, (fig 5.5) exhibiting different roles in the relationship. Findings from the data suggest that both parties in the dyad exhibit dual roles. These, together with the broader sociological influences are discussed below.

7.2 Exploring Roles and Broader Influences in the Physiotherapy Encounter Relationship

In this research physiotherapy clinicians and older patients related at varying levels. Many physiotherapy clinicians presented as having a dual role, that of professional, underpinned and influenced by professional power and that of befriender, underpinned by their perceptions of friendship. Older patients also presented with dual roles; the sick role underpinned by their expectations of health care and a reluctant partner role influenced by their physiotherapy clinician's wish for clinical partnership.

7.2.1 The Professional Role

In this research, many physiotherapy clinicians liked to present as both clinical expert and friendly face. As a clinical expert they must present a professional front capable of instilling confidence, offering an accurate prognosis and imparting bad news when necessary. In their other role they offer many of the components of friendship, listening, empathising, offering advice, sharing personal information and humour.

The "professional role" is socially defined and reinforced by the professional body's rules of professional conduct to which all members must adhere (CSP, 2002b). The rules relate to scope of practice, respect for the "dignity and individual sensibilities of every patient", confidentiality and duty of care. Rule 2 specifically covers "Relationships with Patients" and clearly sets out the duties and boundaries for the physiotherapy clinician. This rule includes the requirement for the physiotherapist to ensure informed consent

through information giving, discussion and encouraging questions. Strict boundaries demark the definition of an inappropriate relationship with a patient including any exploitation of the mutual trust and respect. Close relationships with patients are recognised as inevitable in some circumstances but the rules state, "both the therapist and the patient must be clear that this is well outside therapeutic contact" (Rule 2.8). Relationships are also considered improper if they become "emotional or sexual". The physiotherapy clinicians in this research certainly exhibited their professional role within the relationships with their older patients, adhering to these rules. However, this role could be construed as encouraging a distance that limits engagement with older patients, preventing the physiotherapist from really gaining an insight into their needs and aspirations and potentially limiting full engagement.

The professional role is further reinforced by the social standing given to health care providers by virtue of their ability to "cure" but this also reinforces the power differential and contributes to the professional hierarchy present in health care (Lupton, 1994: chapter 5). This is discussed below.

7.2.2 The Influence of Professional Power

Hierarchy is established through role and the way in which roles are perceived (Schaeffer and Lamm, 1992: 133-134). Social role denotes a set of behaviours and expectations from people who occupy a certain status. Within this research it was apparent that older patients viewed healthcare professionals, as a group, as having higher status by virtue of their knowledge and position within the health service. Although physiotherapy assistants do not have the same professional status as their qualified colleagues, the physiotherapy clinicians felt that this difference had little impact on the way in which older patients viewed assistants initially. The older patients, however, had very little concept of hierarchy within the physiotherapy profession, seeing qualified physiotherapists and assistants as having the same duties, responsibilities and authority.

Although professional status can be described as achieved status, gender can be seen as assigned by society from birth. Although the political and sexual emancipation of

women during the last century has done much to change the roles of women in today's society, the generation of older patients being treated by physiotherapists today will have been brought up in a society that assigned a less influential status to women in the workplace. In this research, although some physiotherapy clinicians noticed a difference in the way they were perceived by their male and female patients this was not frequent and, where it existed, the professional status of the clinician seemed to have precedence over any gender hierarchy. Interestingly, physiotherapy clinicians were not averse to using their secondary social roles as partners, parents, children or friends to ameliorate the perceived professional hierarchy and aim for a more equal partnership.

However, other factors undoubtedly reinforced the power relationship. Non-verbal communication skills and appearance are considered to be the main channel for self-presentation (Argyle, 1994) being the main vehicle for expressing emotions and indicating attitude. Unavoidably the physiotherapy clinician will approach the patient from a dominant standing posture as the patient will almost certainly be seated due to frailty and infirmity – the very reasons why the physiotherapist is involved. Uniform and the tools of the trade including assessment equipment, some of which will be unfamiliar to the patient, reinforce the status of the physiotherapy clinician within the organisation. Given that the older patient may be dressed in casual garments to facilitate exercise, this further reduces their perceived status against that of the smart physiotherapist. The medical records held by the approaching physiotherapist contain a Pandora's Box of information that is not readily accessible to the patient and further reinforces the power of the clinician.

Argyle (1994) suggests that touch is another means of establishing dominance, especially when it is not deemed appropriate for one of the party to reciprocate that touch. This would certainly be true in the physiotherapy clinician / older person encounter where diagnostic, treatment and care touch are seen to be the prerogative of the health care professional, and therapeutic and facilitatory touch the specialist concern of the physiotherapy clinician (Pratt, 1978: Mason, 1985: Martlew, 1996). Although the physiotherapy clinicians state that they sought permission to use touch from the older

patient it is unlikely that many patients in that situation felt empowered to be able to refuse. However, the older patients appeared to perceive touch as in integral and necessary component of physiotherapy treatment and denied any embarrassment, seeing no reason to refuse.

Wilkinson (1999) describes two types of power: authority, which is seen to be legitimate and invested by society; and coercion, which is not accepted as legitimate and possibly based on force. Wilkinson sees older people, as a group, as being disempowered by society solely by virtue of their age. There was neither evidence of overt age discrimination nor of practices that would adversely disadvantage patients purely on the grounds of their age by the participants in this study, with some patients expressing surprise that they were considered "worth treating" in their nineties. This bodes well for the spirit of the National Service Framework for Older People (DoH, 2001a), which advocates equality of attitude and access to health and social services for older people. It could be said that persuading reluctant older patients to comply with treatment when they are already so disadvantaged by their poor health, an unfamiliar environment and the professional / patient hierarchy, is coercion. However, the physiotherapy clinician is torn between the patient choice ("Leave me alone") and professional duty (to rehabilitate). If persuasion is more effective if the source is regarded as expert (Argyle, 1994), and if the influencer is seen as a legitimate source by virtue of his/her ability, experience or rank, perhaps it is not surprising that physiotherapists feel they walk a thin line between facilitation and coercion.

The physiotherapy clinicians stressed the importance of assessment and using the relationship to extract relevant information from the older patient in order to formulate appropriate goals. Although this could be seen as empowering for the patient in that it seeks to ascertain their views about what is important to achieve from the physiotherapy treatment, Waitzkin (1991) and Good (1994) suggest that this too can be used as a covert form of social control as clinicians filter out what they consider to be important and achievable within their professional bounds. However, the role of the environment in which the patient is treated may influence this. Certainly in von Koch et al's study

(1998) a stroke patient treated at home was found to be more likely to feel able to take the initiative in goal setting than patients treated in hospital. Indeed the physiotherapy clinicians interviewed in this study felt that the balance of power in the relationship shifted once the physiotherapist was on the patient's home territory although the older patients' apparent respect for the clinicians' professional authority appeared to override any territorial effect.

7.2.3 The Befriender Role

To temper this hierarchical professional role most physiotherapists and all the physiotherapy assistants in this study also employed a "befriender role". In situations where a physiotherapist and assistant worked together the dual role was observed within that dyad rather than individuals, with the physiotherapist taking the professional and assistant the befriender role, something that eased the potential conflict for both.

A befriender, one who makes a friend of another, implies an active process on the part of the physiotherapy clinician. Friendship both precedes and is a component of society being a human trait enhancing social connectedness (Pahl, 2000: 6) and is a product of human and social evolution (Mithen, 1996: 44). Parsons (1951) debated the nature of the emergence of the social systems considering these to occur through the development of individual friendship relationships. He stated that in order to communicate effectively certain understandings about the nature and content of the relationship needed to be established to allow understandings to emerge around mutual interests. Whilst the participants in this study identified relationships that ranged from purely professional to dependency, most of the older patients favoured a "friendly" relationship with their physiotherapy clinician. This was described as one where a mutual understanding of their needs and the clinician's knowledge and skill would optimise engagement with the therapy. Within this type of relationship there was a pre-existing and tacit understanding of the accepted social and professional boundaries within this dyad although physiotherapy clinicians actively cultivated a friendly atmosphere through showing an interest in the patient and their wider family and interests, a degree of self disclosure and the use of humour. This was perceived as being friendly rather than being a friend.

However, the actions observed and described by participants have many of the categories of the friendship in older age typology as described by Adams et al (2000) and is discussed below. This is interpreted here as the physiotherapy clinician acting as a befriender, that is, making a friend of another albeit for a specific reason time limited by the encounter.

7.2.4 The Influence of Friendship

Pahl (2000) considers friendship to be of especial importance to older people. As their children move away and partners and old acquaintances die, their remaining friends and new friendships take on a special importance particularly for maintaining self esteem and social and psychological well-being. This makes the loss of a physiotherapy clinician considered to be a friend even more poignant as shown by some participants in this research.

Allan (1998) considers that relationship research has moved from the individual to the dyad and the integration of a sociological perspective, having social and cultural rather than personal characteristics. He argues that it is important to locate friendship within the broader context of different levels: personal environment, network, community and societal (Adams and Allan, 1998). In particular the social and economic conditions of people's lives shape their friendship ties. However, the friendships they discuss are assumed to be peer relationships within people's social and work experience based on "individual choice, feelings and commitment" (Allan, 1998), something that is not present in the "friendship" between physiotherapy clinicians and older patients.

Exploring the definitions of friendship in older age, Adams et al (2000) have developed a typology in which the friendship definitions of older people are categorised. They found in their research undertaken in USA and Canada with men and women aged 75 years and older that five broad categories of friendship previously identified from their analysis of the literature were evident. These were the behavioural processes of self-disclosure, sociability (getting along well together), assistance and shared activities; cognitive processes of loyalty or commitment, trust, shared interests or values, acceptance,

empathy and appreciation or respect; affective processes of compatibility and care; structural characteristics of solidarity and homogeneity (for example belonging to the same religion or occupation) and proxy measures of process which are frequency of contact, length of acquaintance and duration of contacts. In Adams et al's research participants were asked about friendships in general and it is assumed that they also described social rather than patient/clinician relationships.

Whilst these broad categories are apparent in friendships between adults of all ages, Adams et al consider that older people have more experience of close relationships and display greater skill with the cognitive, effective and behavioural dynamics of friendship.

Comparing Adams' typology with the findings from the physiotherapy clinicians' and older patients' studies may give some insight into whether these participants' definitions of "friendly" relate to other relationship research. In these studies all participants described at least some of the same characteristics as those identified by Adams et al. These older patients identified self-disclosure and sociability as important and it is inevitable that the physiotherapy clinician will offer assistance within the encounter and this could be construed as a shared activity. However, from these study findings this assistance is only one way and the physiotherapy clinician directs the shared activities that solely comprise the clinical treatment. Certainly elements of loyalty and personal commitment in the relationship were evident from both the physiotherapy clinicians' and older patients' data as were trust, empathy and respect. However, the other elements of the cognitive processes namely shared interests or values and acceptance appear to exist as products of the intervention process rather than the relationship in isolation. Similarly the affective process of compatibility was not evident in the physiotherapy clinician / older patient data undoubtedly because the relationship occurs only because of the clinical intervention, and other than the patients' physiotherapy needs, the dyad has no other need to have anything in common. Care, however, was apparent but only in one direction, from physiotherapy clinician to older patient. No findings established a caring role for the older patient for the physiotherapy clinician although several older patients exhibited caring about the relationship. The structural processes of solidarity and

homogeneity were not particularly apparent although one older patient identified the importance of "both singing from the same hymn sheet". Homogeneity of social background was not an underpinning factor in these "friendships" as, again, such relationships were not socially determined but dictated by the need for clinical intervention. Proxy measures of process, however, were considered important with both parties noting factors of frequency and duration of contact and length of acquaintance as crucial to the maintenance of and satisfaction with the relationship.

Adams et al identify subtle differences between the friendship definitions of men and women, concurring with Wright (1982) that women tend to make "face to face" friendships whereas men are more likely to describe their friendships with other men as "side by side". The small numbers in this study do not allow such comparisons to be made especially as physiotherapy is such a female dominated profession and relatively few male physiotherapy clinician / male older patient dyads occur. Some research has looked at the geographic and cultural impact of friendship (De Vries et al, 1996) but again, these variations were not evident in the small sample in this study.

Adams et al do not report any evidence of power influences in their research. In his discussion paper, Allan (1998) does not specifically consider the experience of friendship as experienced by older people nor the response to imposed encounters in health care. He does, however, consider the impact of status and identity on friendship identifying that where there is a status discrepancy managing friendship can be problematic. This reflects the experiences of the physiotherapy clinicians who felt less comfortable with the power inequalities than did the older patients.

It would appear from the findings of this study and the literature discussed above that the physiotherapy clinicians and older patients describing their relationship as "friendly" are indeed experiencing a friendly encounter as defined by authors describing more social friendship encounters. They appear to be comparable in structure (sociability, duration and frequency of contact) and impact (self disclosure, trust, respect, empathy) but differ in process, being entirely initiated by the need for a service (physiotherapy treatment);

and function, a means of exchanging information for assessment purposes, facilitating compliance (physiotherapy clinician's role) and endearing yourself to the physiotherapy clinician in order to optimise the experience (older patient's role). The over-riding differences between the social friendship and the friendly relationship described within the physiotherapy clinician / older patient encounter are that there is little choice as to whether the clinical encounter occurs and who participates, the fact that the encounter and attendant relationship are time limited by the length of the episode of care and the inherent professional hierarchy.

7.2.5 The Patient or Sick Role

Older patients also have a dual role within the physiotherapy encounter relationship, those of sick patient and reluctant partner. Many may have expectations of dependency and obedience born of their past knowledge and experiences of health care. They bring a need for help to the encounter that they believe the clinician can address. This is influenced by any past experiences and knowledge of physiotherapy. Patients may or may not have expectations about what the treatment will comprise based on previous personal experience or the experiences of their friends and family. Many frequently have anxieties about the treatment and the outcome. Most older patients approach the encounter expecting to be told what to do by the physiotherapy clinician. They are therefore, mostly unprepared for the role of partner expected by the physiotherapist, being unfamiliar with the notion that their opinion will be sought and used to direct their treatment. Many are reluctant to take this responsibility feeling that they are ill equipped to make such a contribution. This role is often considered synonymous with the sick role. Sick role theory as defined by Parsons (1951) is now considered to be only applicable to acute illness (Cott, 1999) and inappropriate to long-term chronic health problems including older persons' rehabilitation. However, an older person admitted to hospital may well present with acute symptoms expecting and expected to take on this sick role. Accepting the sick role exempts the patient from their normal social responsibilities and from the responsibility for being ill. This leads to obligations that the patient must see this illness as being undesirable and seek a return to full health through accessing and complying with legitimate medical advice. Cott (1999) argues that these exemptions and

obligations should not be applied to people with non-acute illness, many of whom are well able to maintain social roles such as employment and family responsibilities as well as managing their own health. The disability movement concurs, seeing the medical profession including physiotherapists as delivering a medical model of health care (Oliver, 1999; Owen Hutchinson, 1998: 406-409). Although a more recent model of the sick role focuses on patient rights and the clinicians' obligations (Haug and Lavin, 1981) this implies a move towards equality of knowledge, responsibility and decision making within the patient/clinician encounter (Cott, 1999). This was something that the older patients in this study had little understanding of or perceived a need for, preferring in the main to leave the responsibility of their rehabilitation to the professionals. However, many older patients presenting with acute illness failed to make a full recovery leaving a degree of chronic illness and disability. It would seem that these older patients have no other model to explain their situation and, not appreciating the subtle change from acute illness to longer term rehabilitation, retain their compliant role expecting it to lead to eventual cure. In this situation the patient moves from the acute sick role to the patient role, which appears to be identical apart from the chronicity of their condition and the unlikelihood of cure. Any disappointment at not achieving cure is tempered by the passive belief that the responsibility for their rehabilitation rests with the professionals and therefore the decision to discharge them from treatment must also be "for the best". This would explain the mix of distress and acceptance displayed by some older patient participants when describing the end of their physiotherapy encounter.

In addition older patients may see loss of independence in older age as an expected part of their chronological life trajectory (Pound et al, 1998a). This appears to concur with this study as, although this topic was not overtly explored, it could be expected that some patients might question the reasons for their health problems ("why me?"). However, none did, all appearing ambivalent and many unquestioningly obedient to their physiotherapy regime. This could explain their reluctance to engage with a different frame of reference that would require more active participation. Bury (1982) describes chronic illness as a biographical disruption requiring a rethinking of the person's self concept but this may not be the experience of the older people in this research presenting

with slow, deteriorating conditions, many of whom appeared to expect the inevitability of decreasing mobility and function with increasing age. This rethinking may be more applicable to previously fit older people suffering a sudden onset of disabling illness (Ellis-Hill and Horn, 2000) such as the participants in this study who had suffered a stroke. The two women with stroke who had completed a course of physiotherapy both showed evidence of rethinking their self-concept from one of independence to modified dependence. Both these women saw their physiotherapy clinician as a friend, expressing distress now that the relationship, as well as the treatment, had ended. Neither of these women identified close social networks and their relationship with their physiotherapy clinician had gained significant importance. In contrast, the man still receiving physiotherapy for stroke was enveloped in a close-knit community of family, friends and neighbours. His self-concept was still one of temporary disadvantage whilst awaiting a full cure probably because he was still receiving treatment and probably not enough time had passed since his stroke for him to develop a new, more permanent, self-concept. The physiotherapy clinician interpreted this as him being unrealistic whilst the patient saw his slow recovery as being due to not having enough treatment. This led to problems with communication and a very fragile physiotherapy clinician/older patient relationship. There is too little data from this study to judge whether there is an association between the development of self-concept, the presence of other close relationships and the depth of the physiotherapy clinician/older patient relationship. Pound et al (1998b) found that having a stroke, whilst considered a crisis, was perceived as one of many crises affecting the lives of older people whose past life experiences rendered them well able to deal with such catastrophes and adapt to new situations. This may not be true for all people, rather a particular factor in the lives of the older, working class people investigated in her study conducted in the East End of London. It did not appear to be the case for the three older patients with stroke in this research.

Corbin and Strauss (1988) suggest that, when entering a period of chronic illness or disability, people have to reconstruct their identities to include this new element. This includes *contextualising* their changes in health and ability into their established biography, *coming to terms* with the consequences of this, *identity reconstitution* – a

process of integration of the old and new self and *biographical recasting* where this new identity construct is included in future life planning. It is unlikely that within the rehabilitation process there is enough time or support for newly disabled older patients to achieve this. Although physiotherapy clinicians insist that they discuss progress, prognosis and discharge with their patients, this is clearly not enough in these cases to enable the patients to move from the sick role.

The patients participating in this research fell into two groups. One comprised those who were rehabilitating following a sudden onset incident such as a stroke or trauma. These patients described full independent lives prior to the insult. The other group described long term, gradual increasing disability without any acute episode. These patients had lived with diminished functional ability and adapted lifestyles for many months or years. However, there was no difference in their adoption of the patient role in their physiotherapy management. It is understandable that patients moving from acute care to rehabilitation should retain elements of the sick role after the acute phase but it would appear that the second group either chose this role automatically being unaware of any alternative or perhaps had it imposed upon them by the hierarchical health system.

7.2.6 The Influence of Health Care Paradigms

Another intrinsic influence behind the encounter is the frame of reference or health care paradigm within which the physiotherapy clinician works. Stenmar and Nordholm (1994) suggest that the physiotherapy profession is seen in one of two ways; either as a "technician type" approach working from a biomedical model or "as a caring profession in which the patient-therapist interaction is emphasised more than the treatment method". The biomedical model is considered to be impairment driven, dependent on diagnosis and treatment of symptoms and disease (Hwu et al, 2001) creating an emphasis on removing the causes of illness rather than promoting health. However, disease is not always identifiable pathologically e.g. chronic fatigue syndrome, which suggests that disease can also been seen as a social construct (Sim, 1990). In addition, many disabled people would consider themselves healthy challenging the value of the medical model in older people's rehabilitation. Similarly, the clinical dominance inherent in this model,

requiring a clinician to take the responsibility for diagnosing and treating disease reinforces the professional power and mitigates against the clinical partnership that the physiotherapy clinician is aiming for.

Illich (1975) argued that conventional medicine had assumed the monopoly on the interpretation and management not only of health and disease but also well-being and disability. Rather than accepting health as being "the absence of disease" (WHO, 1958, p459), Illich defined it as "the process of adaptation to growing up, ageing, disease and death, using the coping mechanisms embedded in the culture and traditions of communities" (Dixon and Sweeney, 2000: 23). The physiotherapy clinicians' study suggests that physiotherapy clinicians see the majority of their work in older persons' rehabilitation falling within the second of Stenmar and Nordholm's models (1994) relating more to helping older people adapt to ageing and disability. The majority of respondents in Stenmar and Nordholm's study felt that the patient's own resources and the physiotherapist-patient relationship rather than treatment techniques were the important factors in explaining why physiotherapy treatment worked. These views were also expressed in this study but here participants felt strongly that the relationship itself was not inherently therapeutic, although they were clear that the relationship was key to optimum partnership in the intervention.

Any professional works not just within professional standards and codes of conduct but also within a professional paradigm or frame of reference. Whilst everyone functions within their own frame of reference, physiotherapists learn their professional paradigm during professional training and with experience, informed by personal bellefs and the philosophy of the employing organisation. In this research the frame of reference of both parties appears to inform the way in which both parties approach and engage within the encounter. Physiotherapy clinicians working in older persons' rehabilitation consider themselves to work within a holistic frame of reference (or rehabilitation approach). This is more akin to Seedhouse's model (Sim, 1990) where physiotherapy clinicians work with the older patients to help them fulfil their "realistic chosen and biological potentials" in order to achieve their own personal optimum health. The terms 'realistic' and 'chosen'

imply an element of mutual insight and partnership, something that the physiotherapy clinicians felt they were achieving.

Thornquist (1994) analysed two physiotherapy encounters and found that the information obtained was adapted to and interpreted within the physiotherapists' biomedical frame of reference. Whilst this physiotherapist took a biomedical approach to the impairment, examining the body as an object extrinsic to the self, the physiotherapist did add a human element through expressing interest in the patient on a human level. Thornquist considers this physiotherapist to be working on two levels with little integration of these two worlds of knowledge. Thornquist's case studies explored single impairment outpatient treatments, which would have been aimed at facilitating cure. Physiotherapy participants in this study consider this approach to be different from the more holistic rehabilitation model used in older persons' rehabilitation. Within a holistic frame of reference it might be expected that these two bodies of knowledge would be more closely integrated. The Thornquist study observed only one male physiotherapist. This study investigated mainly female physiotherapy clinicians and it is not known whether the difference in approach is in any way influenced by the gender of the therapist. However, despite working within older persons' rehabilitation and professing a holistic approach there was evidence of different levels of integration in the four interventions' studies (figs 6.3, 6.4, 6.5, 6.6).

One of the reasons clinicians state for adopting a holistic approach is that the majority of older patients attending for physiotherapy rehabilitation do not present with curable impairments, rather they have disabling conditions that can only be treated to a limited degree leaving the older patient and physiotherapy clinician having to work out methods of managing the residual problems. In this situation it is important for the physiotherapist to look beyond the clinical diagnosis and consider the other factors such as environment or loss of confidence that may be preventing the patient from achieving their full mobility and functional abilities. In some cases these problems are deteriorating rather than static or improving and in these cases the physiotherapy clinician has to walk a thin line between encouraging patients to optimise their capabilities whilst appreciating that these capabilities are diminishing each day. Physiotherapy clinicians working in this field gain

their job satisfaction from assisting older patients to achieve improved quality of life through optimising their ability rather than in effecting cure.

7.2.7 The Reluctant Partner Role

All the physiotherapy clinicians in this research stated that they aimed to work as partners with their older patients. The Chartered Society of Physiotherapy encourages physiotherapy clinicians to work in partnership with patients giving them "independence to choose their own goals for recovery" and make informed treatment choices (Mead, 2000). The physiotherapy clinicians in this study expressed frustration in their thwarted efforts to engage their older patients in a partnership approaching equality of role. The patients in this study appeared reluctant to engage in partnership, preferring the physiotherapy clinician to take the lead. The most common reasons for this were felt to be the patient not considering that their knowledge and input was as important or valued as that of the clinician, feeling that the physiotherapy clinician was the acknowledged expert in rehabilitation or feeling too tired, ill or passive to want to take the responsibility of partnership.

All the physiotherapy clinicians felt they worked towards the current health policy of patient partnership and whilst never identifying a problem with this (most felt they had a working partnership with their older patients) they were clearly adapting this concept to their perceived expectations of this client group. There was little evidence of negotiated goal setting. However, the clinicians remained confident that the treatment goals set by them reflected the patients' own aims through the information gleaned about them at assessment. The older patients' interpretation of partnership was one where the physiotherapy clinician brought the clinical skills and expertise and they brought the motivation, enthusiasm and compliance. Only one dyad was identified where negotiation of treatment aims was apparent and this was with a recently retired trades union officer; someone who was clearly used to negotiating his way towards a preferred outcome.

Cahill (1996), taking a nursing perspective, would express no surprise at these findings seeing patient partnership as sitting at the top of a Maslow type triangle above patient

participation and patient involvement and collaboration which she sees as precursors to any partnership. She quotes the nursing literature defining patient partnership as a working association between nurse and patient in a joint venture based upon a written or verbal contract. This implies obligation and commitment on the part of both patient and clinician. Patient participation, in contrast, is defined by Cahill as an active understanding and participation of the patient in procedures that are primarily clinician led although it can include some relinquishing of power on the part of the nurse and an element of reciprocity from the patient. Mittler and McConachie (1983) writing specifically about people with learning disabilities and their parents define patient involvement as being one way, where the patient's voice is ignored. Jacobs (1980), also writing from a nursing perspective, feels that "patient involvement involves only eliciting patients' perceptions of the situation". Using these definitions it would appear that participants in this research were not achieving partnership but rather differing degrees of involvement and participation.

7.2.8 The Influence of Partnership

Both professional and patient roles could be considered social constructs of modernism, implying the existence of order and hierarchy (Bruce, 1999). These role expectations are clear and based on prior knowledge of social and cultural structures. There are implicit boundaries informed by social and professional codes. In contrast partnership is mooted as a post-modern construct that implies autonomy and individual choice. This concept is mostly alien to older people who have grown up in a more socially disciplined age. Partnership with a health care professional is not normally a role that the older patient instigates.

Partnership in the health service has a long tradition, but has only recently been applied to patients. It is first mentioned in a lecture given by Kenneth Robinson, the then Minister of Health in 1967 (University of Glasgow, 1968) who called for a reorganisation of the Health Service and partnership between the medical profession and government (p18). Over the next decades this partnership extended to relationships between the health care professions. In the seventies, after much negotiation, a government directive gave

physiotherapists autonomy from medical prescription in their choice of treatment (Dyer, 1994) allowing them for the first time to work with rather than for doctors. The growth of multidisciplinary teams in the eighties further developed partnership between the health professions. In the nineties the introduction of NHS Trusts aimed to move health care into local management promoting partnership with the community. Most recently the Department of Health (1999) publication *Patient and Public involvement in the new NHS* has encouraged a more individual partnership with patients. Few would argue that any of these partnerships are perfect and it is against this background that older patients are drawn reluctantly into a form of partnership that they neither understand nor want.

7.3 Role Theory and Conflict

In this research the physiotherapy clinicians and the older patients seemed unaware of any overt duality of role or conflict, yet they enact and adapt their roles continually in response to each other and with increasing expertise as the relationship continues. So, does this apparent duality – or even multiplicity – of role matter?

The concept of role is well defined in the literature and social theory. Biddle (1979) describes role theory as a means of studying the characteristics of persons within contexts (p. 4). Role theory states that roles are associated with social position, often embedded in social systems and some social positions are automatically imbued with power and this is true of the physiotherapy clinicians' professional role. All roles are learned or taught, including the patient's sick role and may be affected by the environment and available resources, as observed in the reinforcement of the physiotherapy clinicians' professional role within the hospital environment.

Physiotherapy clinicians also have other roles such as partner and parent outside of the work environment. Many will also have other roles within the work place such as manager or student supervisor. Similarly older patients have many roles – albeit almost exclusively outside of the health care environment. These have included (in this research) family related roles such as being a spouse, parent, grandparent, child minder, and more community related roles such as social club member and parish councillor.

These many roles go to make up the whole person that portrays themselves in this specific treatment situation as clinician and patient. It is probable that only where there is potential for role conflict within this dyad that this multiplicity of roles has any damaging effect on the relationship. For example, a physiotherapist may cancel a treatment because she has to attend a managers' meeting or an older patient may want to work towards an activity related to another role e.g. playing football with grandchildren that does not coincide with the physiotherapist's own treatment goal for that patient.

However that very multiplicity of roles can have a positive effect on the physiotherapy clinician / older patient relationship. Many clinicians and older patients will share some similar roles for example that of parent, spouse, member of the local community. In this research it has been these very commonalities that have presented the topics for self-disclosure within the relationship, creating common ground between both parties and facilitating the development of confidence and trust between them.

Within this research, difficulties within the relationship were found to arise when a) the extent or boundaries of the professional/befriender and patient/partner roles were set such that one or both of the dyad did not feel comfortable (e.g. physiotherapy clinician 12) and b) where the clinician's role was continually fluctuating between professional and befriender or their expectations of the patient's role varied between that of sick patient and equal partner such that there was no certainty or stability in the relationship (e.g. Observation study, case three) and c) where communication difficulties prevented the identification of mutually acceptable goals (e.g. case 4, older patient and physiotherapist).

These concepts of roles within the physiotherapy encounter relationship are set out against the background of (and are probably specific to):

1. The cohort effect – older peoples' socialisation and expectations of health services
2. The rehabilitation approach –rehabilitation is geared to the management of disability rather than to cure.

These factors too have the potential for conflict. In 1. there is the potential for a generation gap between the physiotherapy clinician and the older patient as the clinician is invariably seen as fit and healthy and, being up to 50 years younger, was not brought up in the same social world. This is managed (as found in this research) through empathy of the clinician and their reflection on the experiences of older people, especially those they know in their own families. No one in this research described a generation gap but all clinicians, bar one on junior rotation, had chosen to work in this field and as such had made a conscious decision to work with older people which may have some bearing on this. Whilst some older patients entered the relationship with some lack of knowledge of what physiotherapy involved, for most, the reality of treatment matched expectations. For example, patients expected a degree of therapeutic touch from their physiotherapy clinician and felt comfortable with it. Similarly, physiotherapy clinicians felt they had a good idea of what to expect from the relationship.

In 2. there is potential for conflict between physiotherapy clinicians' need to enthuse the patient to achieve their full potential whilst remaining honest about prognosis. Physiotherapists manage this by judicious use of physiotherapy assistants to play the "good cop" role whilst retaining some professional distance should the "bad cop" be required. There is some evidence in this research of physiotherapy assistants and technicians adopting a befriender role whilst their senior physiotherapy colleague retains the professional stance. Another means of managing this potential conflict is for the physiotherapist to continually reinforce their professional role through words and actions whilst adopting a friendly approach, rather than behaving as a friend. This includes being honest with the patient from the start even if their management of the patient appears to give off a more optimistic stance.

These findings have culminated in a "Role Model" (fig 6.7) that expresses the basic social concept or key concept of this research. This model illustrates the association between the dual roles portrayed by physiotherapy clinicians and their older patients in the physiotherapy encounter relationship against the existing background of professional hierarchy and aspirations towards equality. Section 7.4 looks at the implications of

professional hierarchy, clinical power and aspirations towards equality in the clinician/patient encounter. It suggests that hierarchy and equality are at odds with each other and that the dual roles taken by physiotherapists and their older patients in order to accommodate this are giving rise to conflict.

7.4 Inherent Professional Hierarchy or Equal Partnership?

This research has identified the potential for conflict between the roles of professional and befriender for the physiotherapy clinician, sick patient and reluctant partner for the older patient and the wider organisational and social conflict between professional power and clinical partnership. These are debated below.

The physiotherapy clinician's professional role and the patient's sick role are separated by the gulf of professional hierarchy that dictates each should play different parts, the patient being subject to the greater knowledge and clinical skill of the therapist. The CSP Rules of Professional Conduct (2002b, Rule 2) acknowledge that the physiotherapist is in a position of power by virtue of their uniform and standing position as opposed to the patient's position of submission characterised by their state of undress and seated or lying posture. Physiotherapists are encouraged to reduce this imbalance by taking a clinical history whilst the patient is fully clad and the physiotherapist sitting facing and making eye contact. This hierarchy describes the power differential in the relationship but the professional body does not identify the inherent professional hierarchy present in the patient / clinician relationship or how a physiotherapy clinician should address this.

The topic of professional power in health care is widely discussed in the philosophy and sociology literature. Weber (1947) defines power as the ability to elicit compliance against resistance and authority as the right to expect compliance. The physiotherapy clinicians in this research certainly did not describe using their professional power overtly as a means of eliciting compliance, although implicit in their professional role was the expectation that the patient would automatically comply with their intervention. They would not agree with the Marxist interpretation of medical power that sees "the doctor as like a sovereign power, exercising control over patients' bodies" (Lupton, 1994: 111).

Foucault (1980) considered such medical dominance an inappropriate term seeing power not as a coercive or controlling force rather an integral part of human relationships, changing between and within situations. He considered power could also be productive and a useful tool for societal order. Skalnik (1999) too distinguishes between power and authority, suggesting that authority has the potential to make power "less predatory". The implication is that authority is vested in a role or individual and subject to scrutiny rather than taken by force and certainly this is true in the clinical situation explored in this research. Skalnik also argues that "personalities give authority to institutions and roles rather than the other way around" (p173). This may be true in the political arena but it is difficult to see how this fits the clinician/patient encounter, as the patient is more likely to be aware of the roles rather than the people occupying them prior to the episode of care.

Lupton (1994: 108) cites Friedson and Starr who state that although medical authority is often necessary to fulfil the demands of the therapeutic process it has extended inappropriately exercising too much control and political power over health care delivery. The physiotherapists in this research certainly accepted that they had authority and the responsibility to use it appropriately to inform and advise their older patients. Sully (1996) states that neither health care professionals nor patients appreciate the power that they exercise within the relationship, nor how they influence others. Certainly none of the participants in this research has considered this.

Several authors state that patients too hold power in the clinical situation through non-compliance and complaints (Sully, 1996), informed consent (Chinthapalli, 2001) having the backing of influential lobbying groups and the media (Calinas-Correia, 2001) and even government backing, as in the case of the then Minister for Health Alan Milburn's response to the Alder Hey report saying he "wanted the balance of power to move away from doctors and shift decisively in favour of the patient" (Canter, 2001).

The older patients within this study acknowledged the existence of professional hierarchy and institutional power. Indeed they expected, even required it to exist, perceiving such hierarchy and power as being part of the orderliness of their social framework. In this

respect they concur with the early writings of Parsons (1937) who, writing in the same era as many of these patients were undergoing formative childhood and early adult experiences, suggested that society exists on different levels of organisation into which individuals must fit. Drawing on the work of Durkheim, Parsons stressed that order in society was due to the cohesive influence of collectively held beliefs and values (Layder, 1994: 14). Certainly the older people in this study appeared perfectly comfortable with the organisational hierarchy within the rehabilitation service, having been brought up in an earlier health system that reinforced the status of health care professionals. In fact, challenging their rather passive and accepting role in this was discomforting to many of them as the very existence of such power relationships gave the older patients a structure and stability to an environment that was usually outside their experience. "Knowing their place" allowed them to take up a particular role, that of naive patient with which they felt comfortable, many having no other role experience to fall back on. It allowed them to relax into the patient role, accepting the knowledge and skill of the physiotherapy clinician without having to make decisions about treatment and goals that they felt they were not competent to make. Lupton (1994) explains this in terms of Foucauldian theory stating that medical dominance is necessary for clinicians to take control in the medical encounter to fulfil the expectations of both parties.

Whilst all the physiotherapy clinicians recognised that professional hierarchy was inherent within the encounter and relationship, all considered that they were working towards partnership with their patients suggesting that they felt the power relationship should to be minimised with some power returned to the patient. They stated using information sharing, listening, showing respect and a befriending approach to facilitate this.

In outpatient settings familiarity was encouraged as part of this friendly approach. In an attempt to make the treatment less formal and reduce the impact of professional hierarchy older patients were often called by their first names. Physiotherapy clinicians all used their first names and claimed that they asked their patients how they would like to be called. However, in this situation there is the potential for the patient's true choice to be

overridden by their perception of how they think the clinician wants them to respond and it is difficult to see how patients could feel comfortable with making such a choice. In some Day Hospital settings first names were automatically used with patients as well as staff wearing name badges. For some, the use of first names was unexpected and tentatively accepted. Only two participants (a retired nanny and a retired head teacher) in day hospital settings had asked to be called by their formal names. Another observation within this research was the use of female (but not male) patients' formal names by (female) physiotherapists in the domiciliary setting unless they had treated them before in hospital settings. As role is determined by context as well as social position (Biddle, 1979) it is not surprising to see different behaviours in different settings. This is an indication of the part played by social hierarchy in the health care settings. Physiotherapy clinicians working in the patient's home environment reported they were also likely to spend more time engaging in non treatment related activities, such as looking at patients' family photographs, than they would in a hospital setting.

Much has been written about patient empowerment which Clarke (1996) suggests is "a partnership suggesting that the principles of mutual understanding, dialogue and discussion necessary to create the shared meaning of an individual's life and health concerns lie at the core of the new clinical relationship between provider and patient". This new relationship includes the sharing of the patient's story, treating the patient as an expert in his own condition and lifestyle, valuing the perspectives of both practitioner and patient, sharing information and expertise, reciprocity and understanding each other's changing role within the relationship (Le May 1998). The physiotherapists in this research certainly felt that patient empowerment could be achieved through engaging with each individual patient and this appears to agree with Foucault (1980) who wrote of "individuals always being in the position of simultaneously undergoing and exercising power" (p98) implying that both parties in the relationship dyad have the capacity for a more equal relationship. In contrast Curtis (2001), citing the abolition of slavery and the emancipation of women states that it is only by changing social practices that people are liberated from constraints. Lupton (1994) agrees, stating that the notion of patients being empowered to take control of the encounter makes little sense as this would call into

question the very reason why the encounter exists (p112-113). However, Le May (1998) considers that older people can be empowered through communication strategies suggesting that this may be limited between older patients and younger clinicians due to generational, language and impairment factors. Another key to empowerment is partnership; the word implying reciprocity and interdependency. Partnerships are reciprocal from the first; even establishing them requires negotiation. The clinician brings attributes of attending, enabling, responding and anticipating and the patient takes an active part in their management and assumes some responsibility for this, affiliate with the health care professionals and interpreting the experience (Le May, 1998). Despite these formulae for developing clinical partnerships between clinician and older patient none are going to be of any value if partnership is not understood, valued or sought by both potential partners as was the case in this research; the older patients apparently accepting of this inequality.

Turner (1986) argues that although inequality is as pervasive in contemporary society as it has been throughout human history, striving for social equality is compatible with human nature, even feasible and desirable (p17). However, this requires political will and social change as personal endeavour is not enough. This is clearly illustrated by the unwillingness of the older patients in this research to engage in a clinical partnership with their physiotherapist even although most were willing to strike up a friendly relationship, some even seeking friendship.

Political change however, is slow in coming. Although the Department of Health document *Patient and Public Involvement in the new NHS* (DoH, 1999) identifies the need to improve patient partnerships in consultation on service delivery and in individual patient/clinician relationships there is little evidence that the actions to do this set out in section 1.11 have been instigated[1]. A more recent Department of Health document

[1] Patient and Public Involvement in the new NHS (DoH 1999), chapter 1, The benefits of patient and public involvement. Key point 11 relates to the need for a positive individual patient – clinician relationship and the role of the clinician in providing relevant information. Three actions are mooted to achieve this: NHSE to take forward regional developmental work to create a positive patient – clinician relationship; Professional regulatory bodies to consider including assessment of clinicians' skills in patient

relating to a programme of change entitled Shifting the Balance of Power claims to "empower frontline patients and staff" (DoH, 2002: 3.3.2). In reality it sets out the changes in clinical and professional leadership with only a concession to patients whose empowerment has clearly yet to be addressed, stating "If we are to devolve power closer to patients we need leaders who can facilitate, motivate and engage clinical staff..."

The National Audit Office (2003) produced a report on "Developing Effective Services for Older People" which "successfully used a variety of methods to consult a wide range of older people". This document differs from previous government papers in that it goes beyond consultation, including older people in policy making. Perhaps this is the start of true political and social change.

This discussion has debated the roles adopted by physiotherapy clinicians and older patients in their clinical relationship against the background influences of professional power, pre-existing models of health care and the current move towards patient partnership. At a human level physiotherapy clinicians want to reduce their professional hierarchy to be seen as friendly and supportive towards their patients. They also seek to empower their patients and use self-disclosure to promote equality at a human level so as to achieve a working partnership. The older patients too respond on a human level, engaging in a friendly and compliant manner. They also want to feel empowered through knowing what is going on and appreciate the information that the physiotherapy clinician is able to give them about their care. Similarly they feel they achieve some equality in the relationship through self-disclosure but partnership is seen purely at the human level of working and getting on well together. From their professional role, conflict may arise for the physiotherapy clinicians who need professional hierarchy in order to establish their professional authority so as to be trusted and complied with. They feel they are empowering the older patient through asking them to take some responsibility for keeping to their physiotherapy programme and feel they achieve partnership in joint goal setting, something that the older patient appears to neither understand nor want.

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communication and partnership un revalidation schemes; All NHS bodies to include patient partnership skills in peer review and appraisal processes.

Thus the roles adopted by physiotherapy clinicians and older patients show little integration and considerable potential for conflict. It would appear that only good interpersonal communication skills from both parties and the older patients' need for the stability of professional hierarchy within the otherwise unfamiliar world of physiotherapy rehabilitation enable the good relationships that so many of the research participants describe. This also suggests that it is impossible to achieve patient empowerment and true clinical partnership whilst professional power influences both the individual roles and the wider social arena in which the physiotherapy encounter relationship occurs.

7.5 Limitations of the study: Grounded Theory Methodology as a research tool for physiotherapy /older patient research

The practical and academic limitations of each part of this study have been identified in earlier chapters. One of the key issues throughout has been the application of a pure grounded theory method in a changing National Health Service setting. The research culture within the NHS has traditionally geared towards pragmatic research and clinical trials. Even although grounded theory has been described as having its roots and processes in a more positivistic epistemology (Charmaz, 2000: 512) and therefore able to sit happily across the qualitative/quantitative divide, being an inductive approach, grounded theory does not fit easily into the NHS traditional research mould.

The majority of older person's mobility and functional rehabilitation following illness or trauma occurs within the National Health Service and it was here that this research was set. As already outlined in 3.2 the precedent for using grounded theory as a means of physiotherapy research is weak, however, the value of the method in developing useful theory from the perceptions and experiences of clinicians and patients has been shown in recent health literature (Kumar and Gantley, 1999; Agee and White Blaxton, 2000; Nichols, 2000; Stephenson and Wiles, 2000; Kumar et al, 2003).

This research has shown that it is feasible to undertake a grounded theory method that results in theory that is applicable to physiotherapy education and service delivery.

However, a number of constraints have militated against the rigorous application of this method and these are discussed below.

Grounded theory is an inductive approach leading to theory development through constant comparison and theoretical sampling. It is an emergent process dependent on a responsive and flexible approach to data collection. The ability to select potential participants to complete gaps in the data or develop categories, theoretical sampling, is a key attribute of grounded theory. As the key concept emerges it is often necessary to undertake further data collection to clarify and test emerging theory. This need to adapt participant inclusion criteria and recruit others in order to saturate data militates against the strict controls of the NHS ethics committee procedures. These dictate that the research method, sample size, inclusion and exclusion criteria, information letters and tools are decided and agreed by the relevant NHS managers and receive Ethics Committee approval prior to any data collection. This seriously inhibits the necessary responsiveness of the grounded theory method, with some Ethics Committees even requiring structured interview schedules, further limiting the responsive, participant led approach. No data may be collected within the NHS without the permission of the relevant service managers. In a rapidly changing NHS this requires continual communication with the Trusts, even whilst data collection is not underway, to determine how the service is changing and the impact this may have on the research. Considerable diplomacy has to be used also to ensure that new staff know about the research and are happy to sanction its continuation. During the three year duration of this study one of the initial single Trusts devolved into three and the Elderly Services department was reorganised. In the other Trust one physiotherapy manager retired and there were two changes of senior physiotherapy manager. Fortunately, although this had implications for the method of data collection (snap shot rather than longitudinal), good communications with key individuals meant that data collection within the agreed limits was only slightly compromised.

The following compromises to the pure theoretical application of grounded theory were made in order to access patients and staff in the NHS Trusts affecting both the research question and the rules of data collection.

- The initial research question sought to explore the development as well as the rationale, role and constituents of the physiotherapy clinician/older patient relationship. Major reorganisation changes in the NHS at the start of the research prevented the original plan of a single longitudinal study from being undertaken.
- One of the key principles of grounded theory is the need to be flexible, sampling theoretically on the basis of earlier analysis in order to develop and saturate categories. Due to the strict requirements of the Ethics Committees such flexibility has been impossible. This was anticipated from the start and a certain amount of freedom built into the ethics applications. This included very broad – if purposive rather than theoretical - sample inclusion criteria and time frames. However, it was not possible to adapt the data collection method with the inclusion of observation nor increase the sample size without returning to the Ethics Committees. The time taken to go through this process also had some bearing on the number of cases able to be researched in the final observation study.
- Concurrent data collection, analysis, identification of concepts and the subsequent modification of data collection tools such as interview guides makes grounded theory a time consuming research method. As this research had to be fitted into a busy clinical service compromises had to be made to the timings and length of data collection.
- Although it was possible to feedback the findings of the clinicians' study to physiotherapists and assistants in order to test and develop the models that arose in line with grounded theory method, it was not possible to do this formally with the older patients due to practical and ethics committee constraints. However, the models arising from the older patients' study were discussed with the older patients observed and interviewed for the final study and their views informed the presentation of these models (chapter 5).

As the research question and data collection techniques were both necessarily compromised, it was perhaps inevitable that the resultant theory would reflect this. Strauss and Corbin (1998a: chapter 4) identify similar practical constraints to the theoretical implementation of grounded theory. These include research question adaptation, the need to balance objectivity and sensitivity and being a participant researcher. This study adds three more potential impacts; fitting this research into a busy clinical department, accommodating ethics committees and maintaining NHS Trust permissions to research in a rapidly changing service.

In debating whether these compromises invalidate the method or actually give a more realistic reflection of the experiences and perceptions of patients and clinicians in a time a resource limited service the Strauss and Corbin (1998a: 7) checklist was used. This identifies the characteristics of a grounded theorist, which could also apply to any qualitative research. These are:

- The ability to step back and critically analyse situations
- The ability to recognise the tendency toward bias
- The ability to think abstractly
- Sensitivity to words and actions of respondents
- A sense of absorption and devotion to the work process
- The ability to be flexible and open to helpful criticism.

This last criterion was ensured through presentations of this research to clinicians, academic colleagues and at national and international conferences. Feedback from these informed analysis and theory development. I have attempted to demonstrate the previous criteria throughout this thesis.

Overall, it would appear that grounded theory method has not been overly compromised by the constraints. The process has been rigorous in that an inductive approach has been used, data has been subjected to constant comparison, interviews have been informed by earlier data analysis and the models and core concept are all grounded in the original data. One criticism is the possibility that purposive sampling has led to forcing of data to

"fit" categories, however, extensive use of reflection and memos have been used to reduce this bias. Another criticism is that, as a clinician, I may have been influenced by obvious service constraints and adapted my research to reduce the load on the physiotherapy service. I acknowledge that my concern for best patient care could have conflicted with the needs of the research, however, I am not aware of any overt situations where this occurred.

The other characteristic of grounded theory method is in the use of literature. Strauss and Corbin (1998a: 49) caution against the researcher becoming "so steeped in the literature that he or she is constrained and even stifled by it". However they concede that a certain amount of background knowledge is required to enhance the data collection. This study has followed these guidelines. An initial literature search into ageing and healthcare services in the United Kingdom was undertaken together with a review of the therapeutic relationship as perceived by health clinicians (Chapter 2). This informed the extent of current service provision and research into this topic. It assisted in finding that there was a question to be answered that was relevant to physiotherapy and informed the early interview guides. However, as the research and analysis continued it became clear that topics identified in the initial literature review such as professional power and partnership needed to be explored further and new topics such as role, equality and befriending needed to be investigated. Thus new searches were undertaken and relevant literature included in this chapter as part of the discussion of findings.

In conclusion, it would appear that despite the constraints, grounded theory method is an appropriate tool for investigating the physiotherapy encounter relationship in older persons' rehabilitation in this research. The key elements of the process have been rigorously applied and where compromises have been made these have been recognised, reflected upon and discussed. In addition, useful theory has emerged that will inform physiotherapy education and, possibly, service delivery (Chapter 8.2). However, because of the constraints, this research is probably only valid within the current older persons' rehabilitation service although its wider application could be tested in other services and with different cohorts.

7.4 Summary

The physiotherapy clinician adopts the role of professional and befriender whilst encouraging the patient to move from sick role to one of partner in order to reduce the impact of professional hierarchy, humanise the experience for the patient and encourage clinical partnership. This research shows that, although the political and individual clinical will is largely present, the deep rooted, entrenched nature of professional power and socialisation, and perhaps the need for patients to maintain this hierarchy in the clinician/patient relationship in order to establish any kind of meaningful role for them, are preventing the move from hierarchy to equality.

Grounded theory method has proved to be a useful and appropriate tool for exploring this topic.

Chapter 8
Exploring the physiotherapy clinician/older patient relationship: conclusion

8.1 Revisiting the Research Question

This study sought to explore the relationship that occurs between physiotherapy clinicians and their older patients in medium to long-term rehabilitation outpatient and domiciliary settings. It has identified that a relationship does exist alongside and because of the clinical intervention. In most cases this relationship is time limited by the length of the episode of care. This relationship has a rationale and role within the physiotherapy encounter. It is considered by physiotherapy clinicians to be a vehicle for clinical intervention, easing an often alien and sometimes frightening experience for the older patient, and as a means of showing empathy and gaining trust and compliance. Older patients too value a good relationship with their physiotherapist, as they feel more able to share information and concerns. Many also appreciate some self-disclosure from their clinician as this makes them feel more equal on a human level. They do not, however, seek equality or partnership at a professional or clinical level. A good relationship is also felt to influence clinical outcome through encouraging trust and compliance with the clinical programme. The relationship is not deemed therapeutic in its own right in the absence of clinical intervention, as would be a psychotherapy relationship. The term therapeutic relationship has undoubtedly evolved through being a relationship that sits alongside a therapeutic encounter. This term is discarded in favour of the term 'physiotherapy encounter relationship' as this acknowledges the existence of a relationship whilst placing it firmly within the clinical intervention and the episode of care.

This research identified constituents to the relationship similar to those found by other health professions. The main differences between physiotherapy encounter relationships and those formed by other health professionals appear to be the time available to form the relationship, both within the individual treatment sessions and across the course of treatment, and the continuity of treating clinician.

New information arising from this research was the apparent duality of role adopted by the physiotherapy clinicians and imposed on the older patients. Although there is undoubtedly a cohort effect specific to older patients in rehabilitation settings, the professional hierarchy inherent in the health service reinforces the professional role of the clinician and the sick role of the patient. Attempts to equalise this by adopting a befriending approach and drawing the older patient into a clinical partnership can be confusing for the older patient and cause conflict for the physiotherapy clinician. The clinicians are not overtly aware of this conflict or of the older patients' confusion. Some clinicians have developed strategies for managing this conflict through separating professional and befriender roles overtly in their communications with patients or by encouraging physiotherapy assistants to play the "good cop" role whilst the qualified physiotherapists retain a professional distance allowing them to play the 'bad cop' role when needing to impart difficult information about prognosis or discharge.

Whilst exploring clinician / patient partnership was not a key aim of this research, the topic has arisen in the findings and raises new questions. As partnership with patients is a basic tenet of current NHS policy these findings add to the debate of how this partnership can be achieved. One supposition arising from these findings is that physiotherapists are not adequately discussing or communicating their changing goals with their older patients. Although the physiotherapy clinicians in this study felt that they were communicating well with their patients, there was evidence of lack of understanding on the part of the patients. They also maintained that they took a holistic approach to older patient treatment although they had all initially trained in the medical model of health care aiming first to address impairment and only moving onto the management of activity (disability) and participation (handicap) when it becomes clear that 'cure' is not achievable. Physiotherapists usually identify impairments at initial assessment that lead to their early intervention goals. It is suggested that they may intuitively move these goals from impairment to activity to participation as full recovery appears less likely, but without making this clear to their patients. The encouraging, befriender relationship along with the authoritative, professional approach may reinforce the potential for full recovery in the mind of the patient. When this does not occur and the physiotherapist

moves on to assisting the patient to manage their disability it is not known whether the patient appreciates this and it may well be that they are continuing to expect a cure for their impairment. This would certainly explain why some patients feel dissatisfied with the outcome of physiotherapy rehabilitation (Wiles et al 2002).

8.2 Implications for Physiotherapy

The findings of this research have implications for the physiotherapeutic management of older patients. The following recommendations are made for practice and education:

- Include the physiotherapy encounter relationship in communications training for undergraduate physiotherapy students

- Include training in optimising the physiotherapy encounter relationship in post registration continuing professional development for clinical physiotherapists and physiotherapy assistants including increasing awareness and promoting discussion of the duel roles played by both parties within the dyad.

- The Professional Body (Chartered Society of Physiotherapy) needs to consider the impact as well as the value of the physiotherapy encounter relationship and be more candid about the impact of power differentials and their impact on patient partnership in its professional standards.

- An exploration is needed of the ethical implications of the potentially manipulative qualified physiotherapist/physiotherapy assistant working practices in juggling professional and befriender roles within the physiotherapy encounter relationship.

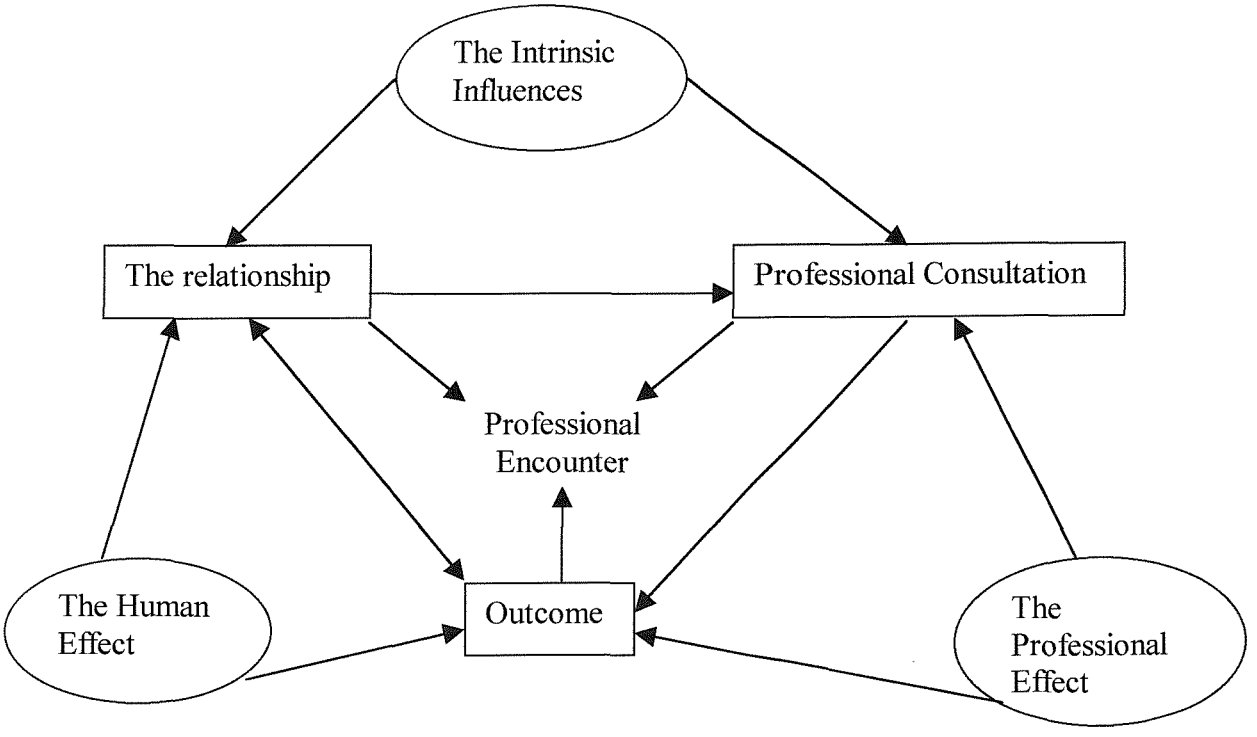
- Further research is needed into the supposition that poor patient partnership with older patients is linked to physiotherapy clinicians' lack of awareness and understanding of the roles played out by the actors within the encounter.

- Further research is needed to explore the suggestion that patient partnership is limited by poor communication of the changing paradigms adopted by the physiotherapy clinicians as treatment goals change from impairment to activity to participation led.

8.3 Wider Implications

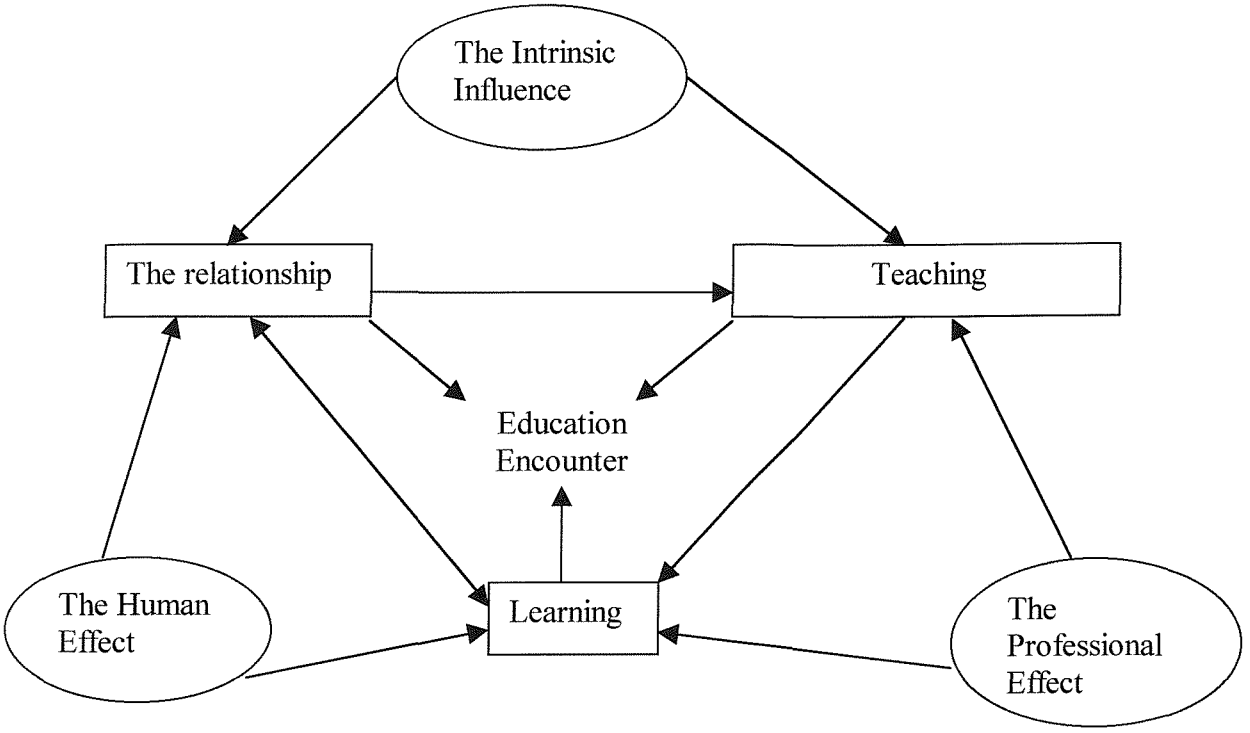
The models arising from this research have the capacity for wider significance and application within and beyond physiotherapy. Model 1, Conceptualising the Relationship within the Physiotherapy Encounter, could easily describe other healthcare professional/patient relationships. It also has the capacity to relate to other professional/lay encounters that comprise a professional consultation as shown below.

Figure 8.1 Conceptualising the Relationship within a Professional Encounter



An example of adapting this model for education encounters appears in figure 8.2 below.

Figure 8.2 Modifying the Model in an Education Encounter



Here the teacher/pupil relationship exists alongside, because of and time limited by the topic being taught. Teaching and the relationship are impacted upon by intrinsic influences including professional hierarchy and pre-existing factors relating to the service within which the encounter occurs. Teaching aims to promote learning through the professional effect of skills and expertise. Learning influences and is influenced by the human effect of the teacher and pupil in the same way that healing is influenced by and influences the physiotherapy encounter relationship.

Similarly the model (Figure 5.5) describing the physiotherapy clinician and older patients' level of engagement within the encounter is likely to be transferable to other professional relationship scenarios, with the professional presenting him/herself on a continuum from a technical approach to a personal relationship and the lay person responding on a continuum from self contained to dependency. All professions work within stated boundaries policed by their professional bodies and as such it could be

assumed that relationships occurring at the extremes of the continua could be deemed ineffectual or inappropriate as in this research.

The key concept arising from this research, the Role Model (Figure 6.7) may also have resonance with other professional/lay relationships. Certainly the central part of the model is likely to be transferable to those relationships occurring within pre-determined or preconceived frames of reference and within a professional hierarchy. Transferability of the duality of role on the part of the professional person i.e. the professional and befriender roles is also almost certainly appropriate. However, the duality of the layperson role as a passive accepting individual and reluctant partner will depend on their understanding of the extent and responsibility of their role within the encounter and their willingness to challenge or actively engage with the "expert" stance of the professional. This will not only depend on the character of the layperson but also on how socially acceptable it is deemed to do this. This may well vary between different professional encounters.

Whilst these deliberations are of interest it is vital to test the models, in this instance against the relevant professional/lay encounters, before applying them with any certainty. Assumptions of the reasons behind participants presenting with dual roles and the potential for role conflict within other relationships cannot be extrapolated from this research but might provide leads for further investigation. If these models were found to be equally applicable in other professional/lay encounters they could inform the balance between human and professional influences to best effect and give an insight into the significance that intrinsic factors have in influencing the encounter.

8.4 In Conclusion

The relationship is an integral and important part of the physiotherapy encounter in older persons' rehabilitation. Good relationships are perceived to enhance or speed clinical outcome. The relationship is considered to be especially important in the enhancement of quality of life and well-being in the absence of cure. Physiotherapy clinicians and older patients are, in the main, unaware of the dual roles they play. These remain un-integrated

and a potential for conflict capable of disrupting both the relationship and the wider encounter. However, most physiotherapy clinicians, without being overtly aware of the dual roles they adopt, have adapted their way of working to accommodate these and maintain good relationships with their older patients. Similarly the older patients are equally unaware of their dual roles tending to remain within the more familiar patient role. Their partnership role is characterised more by a move to a form of equality within the relationship rather than taking on the role of full clinical partner. The models arising from this research have the potential to describe other relationships in healthcare and wider professional/lay encounters.

The dualities identified in this research reflect the wider conflict within the broader influences of professional hierarchy and friendship, the prescribed format of the delivery of health care within the medical model and the wish for clinical partnership. Until these broader influences can be reconciled within health services and wider society it is unlikely that the role duality of physiotherapy clinician and older patient can be resolved.

References

Adams, R and Allen, G (1998) *Placing Friendship in Context.* Cambridge University Press, Cambridge, UK

Adams, R, Blieszner, R and de Vries, B (2000) 'Definitions of friendship in the Third Age: age, gender and study location effects' *Journal of Aging Studies,* **14,** 1, 117-133

Agee, A and White Blanton, P (2000) 'Service providers' modes of interacting with frail elders and their families: Understanding the context for caregiving decisions.' *Journal of Aging Studies* **14,** 3, 313-333

Alexander, DA (1973) 'Yes, but what about the patient?' *Physiotherapy,* **59,** 12, 391-393

Allan, G (1998) 'Friendship, sociology and social structure' *Journal of Social and Personal Relationships,* **15,** 5, 685-702

Andrews, GR (2001) 'Promoting health and function in an ageing population.' *British Medical Journal* **322,** (24 March) 728-729

Angrosino, MV and Mays de Pérez, KA (2000) 'Rethinking observation: from method to context' in Denzin, NK and Lincoln, YS (eds) *Handbook of Qualitative Research Second Edition,* Sage Publications, Thousand Oaks

Arber, S (1998) 'Health, ageing and older women' in Doyal, L (ed) *Women and Health Services.* Open University Press, Buckingham

Archer, RL (1979) 'Anatomical and psychological sex differences' in Chelune, GJ, Archer, RL, Kleinke, CL, Civikly, JM, Derlega, VJ, Doster, JA, Grzelak, J, Herron, JR, Nesbitt, JG, Rosenfeld, LB, Taylor, DA and Waterman, J (eds) *'Self disclosure: Origins, patterns and implications of openness in interpersonal relationships'* Jossey-Bass, San Francisco

Argyle, Michael (1994) *'The Psychology of Interpersonal Behaviour. Fifth Edition'* Penguin Books, London

Argyle, M, Furnham, A and Graham, JA (1981) *'Social Situations'* Cambridge University Press, Cambridge

Bäckström, B and Dahlgren, L (2000) 'Vojta Self Training: Experiences of six neurologically impaired people' *Physiotherapy* **86,** 11, 567-574

Barbour, R (2001) 'Checklists for improving the rigour in qualitative research: a case of the tail wagging the dog?' *British Medical Journal'* **322**: (5th May), 1115-1117

Barnard, S (2001) *'Attitudes of new graduate physiotherapists towards older people. Research report'* Health and Rehabilitation Research Unit, School of Health Professions and Rehabilitation Sciences, University of Southampton

Bartlett, D and Payne, S (1997) 'Grounded Theory – Its basis, rationale and procedures' in McKenzie, G, Powell, J and Usher R *'Understanding Social Research: Perspectives on Methodology and Practice'* Falmer, London

Bernstein, L, Bernstein, RS (1980) *'Interviewing: A Guide for Health Professionals (3rd edition)'* Appleton-Century-Crofts, New York

Biddle, BJ (1979) *'Role Theory: Expectations, Identities and Behaviors'* Academic Press Ltd, New York

Bloom, SW (1963) *'The Doctor and his Patient'* Russell Sage Foundation, New York

Bloom, S and Summey, P (1978) 'Models of the doctor-patient relationship: a history of the social system concept' in Galaher EB (ed) *The Doctor Patient Relationship in the Changing Health Scene* pp17-41 Dept HEW, Washington DC

Bone, MR, Bebbington, AC, Jagger, C, Morgan, K and Nicholaas, G (1995) *'Health expectancy and its uses'* HMSO, London

Bourhis, RY, Roth, S, MacQueen, G (1989) 'Communication in the hospital setting: a survey of medical and everyday language use amongst patients, nurses and doctors.' *Social Science in Medicine* **28**, 4, 339-346

Bowlby, J (1973) *'Separation. Attachment and Loss, volume 2'* Basic Books, New York

Bowling, A (1997) *'Research Methods in Health: Investigating Health and Health Services'* Open University Press, Buckingham

Bowman, C, Johnson, M, Venables, D, Foote, C and Kane, RL (1999) 'Geriatric care in the United Kingdom: aligning services to needs' *British Medical Journal* **319**, (23 October), 1119-1122

Bruce, S (1999) *'Sociology: A very short introduction'* Oxford University Press, Oxford

Bullock, R (2000) 'It is time for simple rules and bold aims' *Therapy Weekly* Sept 14th, 4

Burnard, P (1992) *'Effective Communication Skills for Health Professionals. Therapy in Practice'* Chapman Hall, London

Bury M (1982) Chronic illness as biographical disruption. *Sociology of Health and Illness* **4,** 2, 167-182

Bury M (1997) *Health and Illness in a Changing Society.* Routledge, London

Bytheway B (1995) *Ageism.* Open University Press, Buckingham

Cahill J (1996) Patient participation: a concept analysis. *Journal of Advanced Nursing* **24,** 561-71

Calinas-Correia J (2001) Patient power requires patient freedom http://bmj.com/cgi/eletters/323/7310/414#EL14 (10/12/01)

Caney D (1983) Competence - can it be assessed? *Physiotherapy* **69,** 9, 302-304

Canter R (2001) Patients and medical power. *British Medical Journal* **323**, (Aug 25) 414-415

Charmaz K (2000) Grounded Theory: Objectivist and constructivist methods in Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research, second edition* 509-535 Sage publications, Thousand Oaks, Ca

Chartered Society of Physiotherapy (1996-1997) *Current Awareness Bulletins.* Chartered Society of Physiotherapy, London

Chartered Society of Physiotherapy (1999- 2001) *Physiotherapy Effectiveness Bulletins.* Chartered Society of Physiotherapy, London

Chartered Society of Physiotherapy (2000) *Core Standards 3rd Edition.* Chartered Society of Physiotherapy, London

Chartered Society of Physiotherapy (2002a) *CSP Curriculum Framework.* Chartered Society of Physiotherapy, London

Chartered Society of Physiotherapy (2002b) *Rules of Professional Conduct, 2nd Edition* Chartered Society of Physiotherapy, London

Cheater A (1999) Power in the Post- modern Era. In Cheater A (ed) *The Anthropology of Power: Empowerment and Disempowerment in Changing Structures.* Routledge, London

Chinthapalli R (2001) *Power and duty* http://bmj.com/cgi/eletters/323/7310/414

Collins NL and Millar LC (1993) *The disclosure – liking link: From meta-analysis towards a dynamic reconceptualisation.* Unpublished manuscript, University of New York, Buffalo

Conte V (1999) *Work with a seriously disturbed patient in Gestalt therapy: The evolution of a therapeutic relationship.* Gestalt **3**, 2

Cook FM and Hassenkamp A-M (2000) Active rehabilitation for chronic back pain. *Physiotherapy* **86,** 2, 61-68

Corbin J and Strauss A (1988) *Unending Work and Care: Managing Chronic Illness at Home* Jossey-Bass Publishers, San Francisco

Cott C (1999) Long term care: Living with chronic illness. In Ramsden EL (ed) *The Person as Patient: Psychological Perspectives for the Health Care Professional.* WB Saunders Company Ltd, London

Coyne IT (1997) Sampling in qualitative research. Purposeful and theoretical sampling: merging or clear boundaries? *Journal of Advanced Nursing* **26**, 623-630

Curtis M (2001) *Regimes of truth, patients and medical power* http://bmj.com/cgi/eletters/323/7310/414

Daubenmire MJ, Searles SS, Ashton CA (1978) A methodological framework to study nurse-patient communication. *Nursing Research* **27,** 5, 303-309

Denes M (1980) Paradoxes in the therapeutic relationship. *The Gestalt Journal* **3**,1

Department of Health (1997) *The New NHS: modern, dependable.* The Stationery Office, London

Department of Health (1998) *A First Class service: quality in the NHS.* Department of Health, London

Department of Health (1999) *Patient and Public involvement in the new NHS.* Department of Health, London

Department of Health (2001a) *National Service Framework for Older People.* Department of Health, London

Department of Health (2001b) *Free nursing care for all introduced from today.* Press release 2001/0455 Department of Health, London

Department of Health (2002) *Shifting the Balance of Power: the next Steps.* Department of Health, London

Derlega VJ, Metts S, Petronia S and Margulis ST (1993) *Self-disclosure.* Sage Publications, Newbury Park

Dixon DA and Maxwell M (1985) The interpersonal dimension of physiotherapy: implications for training. *Physiotherapy* **71**, 7, 306-310

Dixon M and Sweeney K (2000) *The Human Effect in Medicine: Theory, Research and Practice.* Radcliffe Medical Press, Abingdon

Donabedian A (1979) The quality of medical care: a concept in search of a definition. First Ward Darley Lecture *Journal of Family Practice* **9,** 277-284

Duck S (1994) *Dynamics of Relationships.* Sage Publications, Thousand Oaks

Dyer L (1994) The profession and the government. *Physiotherapy* **80A,** 70A-71A

Dyson J (1996) Nurses' conceptualizations of caring attitudes and behaviours. *Journal of Advanced Nursing* **23,** 6, 1263-1269

Ebrahim S (1999) Demographic shifts and medical training. *British Medical Journal* **319**, (20 November) 1358-1360

Ebrahim S (2002) The medicalisation of old age. *British Medical Journal* **324**, (13 April) 861-863

Ellis-Hill CS and Horn S (2000) Change in identity and self concept: a new theoretical approach to recovery following stroke. *Clinical Rehabilitation* **14**: 279-287

Fadlon J and Werner S (1999) The relationship between health practitioner and patient. In Ramsden E L (1999) *The Person as Patient* W B Saunders Company Ltd, London

Farthing D (1973) My thoughts as a patient. *Physiotherapy* **58,** 12, 393-394

Fennel G, Phillipson C and Evers H (1988) *The Sociology of Old Age.* Open University Press, Milton Keynes

Finklestein V (1988) To deny or not to deny disability. *Physiotherapy* **74,** 12, 650-651

Fitzpatrick RM, Hopkins AP and Harvard Watts O (1983) Social dimensions of healing: a longitudinal study of outcomes of medical management of headaches. *Social Science in Medicine* **17,** 8, 501-510

Ford P (1995) What older people value in nursing. *Nursing Standard* **9,** 20, 25-28

Fosbinder D (1994) Patient perceptions of nursing care – an emerging theory of interpersonal competence. *Journal of Advanced Nursing* **20,** 6),1085-1093

Foucault M (1980) *Power / knowledge.* Gordon C (ed) Harvester Wheatsheaf, New York

French S (1990) Ageism. *Physiotherapy* **76,** 3, 178-182

Fries JF (1980) Aging, natural death and the compression of morbidity. *New England Journal of Medicine* **303,** 130-135

Frontline (2000) *Ageism Tsar.* (15 November) 7, Chartered Society of Physiotherapy, London

Gaines SO and Liu JH (2000) Multicultural/multiracial relationships in Hendrick C and Hendrick SS (eds) *Close Relationships, A Sourcebook.* Sage Publications, Thousand Oaks

Gard G, Gyllensten AL, Salford E, Ekdahl C (2000) Physical therapists' emotional expressions in interviews about factors important for interaction with patients. *Physiotherapy* **86,** 5, 229-240

Gartland GJ (1984) Teaching the therapeutic relationship. *Physiotherapy Canada* **36,** 25-27

Gibson BE and Martin DK (2003) Qualitative research and evidence based physiotherapy practice. *Physiotherapy* **89,** 6, 350-358

Glaser B (1967) The Discovery of Grounded Theory. Aldine, Chicago

Glaser, B (1969) The constant comparative method of qualitative analysis in McCall GJ and Simmons JL *Issues in Participant Observation.* Addison-Wesley Reading, Mass.

Glaser B (1978) *Theoretical Sensitivity.* Sociology Press, Mill Valley, California

Glaser BG and Strauss AL (1967) *Discovery of Grounded Theory: Strategies for Qualitative Research* Aldine Publishing Company, New York

Good BJ (1994) *Medicine, Rationality and Experience: An Anthropological Perspective.* Cambridge University Press, Cambridge

Government Actuary's Department, Office for National Statistics (1999) *National population projections; 1996 based.* Stationery Office, London (series PP3 no. 21)

Green J (1998) Commentary: Grounded Theory and the constant comparative method. *British Medical Journal* **316,** (4th April) 1064-5

Greene MG, Adelman RD, Friedmann E, Charon R (1994) Older patient satisfaction with communication during an initial medical encounter. *Social Science in Medicine* **38,** 9, 1279-1288

Grimley Evans J (1997) Geriatric medicine: A brief history. *British Medical Journal* **315,** (25 October), 1075-1077

Grimley Evans J and Tallis RC (2001) A new beginning for care for elderly people? **British Medical Journal 322,** (7 April), 807-808

Grundy E (1997) The health and health care of older adults in England and Wales 1841-1994. In Charlton J and Murphy M (eds) *The Health of Adult Britain 1841-1994.* Sationery Office, London 182-203

Guba EG and Lincoln YS (1998) Competing paradigms in qualitative research in Denzin NK and Lincoln YS (eds) *The Landscape of Qualitative Research: Theories and Issues* (chapter 6) Sage Publications, Thousand Oaks

Gubrium JF and Holstein JA (2000) Analyzing Interpretive Practice in Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research second edition* (chapter 18) Sage Publications, Thousand Oaks

Guerrero LK and Andersen PA (2000) Emotion in close relationships in Hendrick C and Hendrick SS (eds) *Close Relationships, A Sourcebook* Sage Publications, Thousand Oaks

Hagedorn R (1995) *Occupational Therapy: Perspectives and Processes.* Churchill Livingstone, Edinburgh

Hailstone JD (1969) The importance of the relationship between physiotherapist and patient. *Physiotherapy* **55,** 230-232

Hall T and Lloyd C (1990) Non-verbal communication in the health care setting. *British Journal of Occupational Therapy* **53,** 9, 383-386

Hall J, Roter D, Katz N (1987) Task versus socio-emotional behaviors in physicians. *Medical Care* **25,** 399-412

Harrison K and Williams S (2000) Exploring the power balance in physiotherapy *British Journal of Therapy and Rehabilitation* 7, 8, 355-361

Helman C.G. (2001) Placebos and Nocebos: the cultural construction of belief in Peters D (ed) *Understanding the Placebo Effect in Complementary Medicine: Theory, Practice and Research.* Churchill Livingstone, Harcourt Publishers Ltd, London

Help the Aged (2002) *Age Discrimination in Public Policy.* Help the Aged, London

Heath I (2000) Dereliction of duty in an ageist society. *British Medical Journal* **320,** (27 May), 1422

Holloway I (1997) *Basic Concepts in Qualitative Research.* Blackwell Science Limited, Oxford

Hough A (1987) Communication in health care. *Physiotherapy* **73,** 2, 56-59

Hwu Y-J, Coates VE, Boore JRP (2001) The evolving concept of health in nursing research: 1988-1998 *Patient Education and Counseling* **42**, 105-114

Illich I (1975) *Medical Nemesis. The Expropriation of Health.* Calder and Boyars, London

Jacobs KD (1980) Does the nurse practitioner involve the patient in his care? *Nursing Outlook* **28**, 8, 501-505

Johnson R (1993) Attitudes don't just hang in the air.... Disabled people's perceptions of physiotherapists. *Physiotherapy* **79**, 9, 619-627

Jones M, O'Neill P, Waterman H, Webb C (1997) Building a relationship: communications and relationships between staff and stroke patients on a rehabilitation ward. *Journal of Advanced Nursing* **26**, 1, 101-110

Kaufman SR (1994) In-depth interviewing. In Gubrium JF and Sankar A (Eds) *Qualitative Methods in Aging Research* (Chapter 8) Sage Publications, Thousand Oaks

Keen J and Packwood T (1995) Qualitative research: Case study evaluation. British Medical Journal **311** 444-446

Khaw K-T (1999) How many, how old, how soon? *British Medical Journal* **319,** (20 November) 1350-1352)

Klaber Moffat JA, Richardson PH (1997) The influence of the physiotherapist-patient relationship on pain and disability. *Physiotherapy Theory and Practice* **13,** 89-96

King J (1989) Educating patients: a change of approach. *Horizons* March 177-180

Kirkwood TBL (2002) Evolution of Ageing. *Mechanisms of Ageing and Development* **123,** 7, 7-745

Kumar S and Gantley M (1999) Tensions between policy makers and general practitioners in implementing new genetics: grounded theory interview study. British Medical Journal **319**, 1410-3

Kumar S, Little P and Britten N (2003) *Why do general practitioners prescribe antibiotics for sore throats? Grounded theory interview study.* British Medical Journal **326,** (18th January) 138

Kumlin I W, Kroksmark T (1992) The first encounter: Physiotherapists' conceptions of establishing therapeutic relationships. *Scandinavian Journal of Caring Sciences* **6,** 1, 37-44

Laslett P (1978) The history of ageing and the aged. In Carver V and Liddiard P (eds)*The Ageing Population* The Open University with Hodder and Stoughton Educational, Seven Oaks

Layder D (1994) *Understanding Social Theory* Sage Publications, London

Lea A, Watson R, Deary IJ (1998) Caring in nursing: a multivariate analysis. *Journal of Advanced Nursing* **28,** 3, 662-671

Le May A (1998) Empowering older people through communication. In Kendall S (ed) *Health and Empowerment: Research and Practice*. Arnold, London

Limandri B (1989) Disclosure of stigmatising conditions: The discloser's perspective. *Archives of Psychiatric Nursing* **3,** 69-78

Lloyd C, Maas F (1991) The therapeutic relationship. *British Journal of Occupational Therapy* **54,** 3, 111-113

Lloyd C and Maas F (1993) The helping relationship: the application of Carkhuff's model. *Canadian Journal of Occupational Therapy* **60,** 2, 83-89

Lloyd M and Bor R (1996) *Communication Skills for Medicine*. Churchill Livingstone, London

Lothian K and Philp I (2001) Maintaining the dignity and autonomy of older people in the healthcare setting. *British Medical Journal* **322**, (17th March) 668-670

Ludwig MJ (1999) *Physician-patient relationships. Ethics in medicine*. University of Washington School of Medicine
http://eduserv.hscer.washington.edu/bioethics/topics/physpt.html (16/11/1999)

Lupton D (1994) *Medicine as Culture: Illness, Disease and the Body in Western Societies.* Sage publications, London

Lyons M (1994) Reflections on client-therapist relationships. *Australian Journal of Occupational Therapy* **41,** 27-29

MacKintosh C (2000) "Is there a place for "care" within nursing?" *International Journal of Nursing Studies* **37,** 4, 321-327

Martlew B (1996) What do you let the patient tell you? *Physiotherapy* **82,** 10, 558-565

Mason A (1985) Something to do with touch. *Physiotherapy* **71,** 4, 167-169

Mason J (1996) *Qualitative Researching.* Sage Publications, London

Mays N and Pope C (1995) Qualitative research: Rigour and qualitative research. *British Medical Journal* **311,** (8th July) 109-112

McCorkle R (1974) Effects of touch on seriously ill patients. *Nursing Research* **23,** 2, 125-132

McMillan RC (1995) Responsibility to or for in the physician-patient relationship. *Journal of Medical Ethics* **21,** 112-115

McQueen A (2000) Nurse-patient relationships and partnership in hospital care. *Journal of Clinical Nursing* **9,** 5, 723-731

Mead J (2000) Patient partnership *Physiotherapy* **86**, 6, 282-284

Millar PA, Geddes EL, Edey LE (1996) Loss, Grief and the Therapeutic Relationship. *Physiotherapy Canada* (Fall), 240-243

Millward L (1995) Focus groups. In Breakwell G, Hammomd S, Fife Schaw C *Research Methods in Psychology.* Sage Publications, London

Mithen S (1996) *The Prehistory of the Mind.* Thames and Hudson Ltd, London

Mittler P and McConachie H (1983) *Parents, Professionals and Mentally Handicapped People: Approaches to Partnership.* Croom Helm, London

Morse JM (1991) Negotiating commitment and involvement in the nurse-patient relationship *Journal of Advanced Nursing* **16**, 455-468

Morse J (2000) Determining sample size. (Editorial) *Qualitative Health Research* **10,** 1, 3-5

Mosey AC (1986) *Psychosocial Components of Occupational Therapy.* Raven Press, New York

Murphy E (1999) With respect to old age. *British Medical Journal* **318**, (13 March) 681-682

Myerscough PR, Ford M (1996) *Talking with Patients: keys to good communication.* Oxford Medical Publications, Oxford

National Audit Office (2003) *Developing Effective Services for Older People.* The Stationery Office, London

Nettleton S (1995) *The Sociology of Health and Illness.* Polity Press, Blackwell Publishers, Oxford

Newland E (1997) *Therapeutic Relationship Review.* http://network54.com/Realm/synchrony/Ther_Rel_Review/TRR_print_M.html (16/11/2000)

Nicholls David A (2000) Breathlessness: A qualitative model of meaning. *Physiotherapy* **86,** 1, 23-27

Norman A (1987) *Aspects of ageism: A discussion paper.* Centre for Policy on Ageing, London

Niolon R (1999) *The Therapeutic Relationship – Part 1* Resources Psychpage http://www.psychpage.com/learning/library/counseling/thxrel.html (16/11/2000)

Office for National Statistics (2003) *Census 2001: National Report for England and Wales* http://www.statistics.gov.uk (18/8/2003)

Ogden J (1996) Doctor-patient communication and the role of health professionals' health beliefs in *Health Psychology: A Textbook.* Open University Press, Buckingham

Oliver M (1999) The disability movement and the professions *British Journal of Therapy and Rehabilitation* **6**, 8, 377-379

Olsen DP (1997) When the patient causes the problem: the effect of patient responsibility on the nurse-patient relationship. *Journal of Advanced Nursing* **26,** 3, 515-522

Oschman JL (2000) Energy medicine – the new paradigm. In Charman RA (ed) *Complementary Therapies for Physical Therapies* Butterworth-Heinemann, Oxford

Owen Hutchinson JS (1998) Health, health education and physiotherapy practice. In French S (ed) *Physiotherapy: a psychosocial approach, second edition* Butterworth Heinemann, Oxford

Pahl R (2000) *On Friendship.* Polity Press, Cambridge

Parry Anne (1990) How do you think about physiotherapy? *Physiotherapy* **76**, 4, 197

Parsons T (1937) *The Structure of Social Action.* McGraw-Hill, New York

Parsons T (1951a) *The Social System* Routledge, London

Parsons T (1951b) Social structure and dynamic process: the case of modern medical practice. In Talcott Parsons *The Social System.* The Free Press, New York

Patistea E, Siamantra H (1999) A literature review of patients' compared with nurses' perceptions of caring: Implications for practice and research. *Journal of Professional Nursing* **15,** 5, 302-312
Patton M (1990) *Qualitative Evaluation and Research Methods.* Sage Publications, Newby Park, California

Peloquin SM (1988) Linking purpose to procedure during interactions with patients. *American Journal of Occupational Therapy* **42,** 12, 775-781

Peloquin SM (1990) The patient-therapist relationship in occupational therapy: understanding visions and images. *American Journal of Occupational Therapy* **44,** 1, 13-21

Phillips K, Woodward V (1999) The decision to resuscitate: older people's views *Journal of Clinical Nursing* **8,** 753-761

Pocket Oxford Dictionary. (1992) Oxford University Press, Oxford

Pound P, Gompertz P, Ebrahim S (1998) A patient-centred study of the consequences of stroke. *Clinical Rehabilitation* **12,** 4, 338-347

Pound P, Gompertz P, Ebrahim S (1998) Illness in the context of older age: the case for stroke *Sociology of Health and Illness* **20,** 4, 489-506

Pratt JW (1978) A psychological view of the physiotherapist's role. *Physiotherapy* **64,** 8, 241-242

Pratt JW (1989) Towards a philosophy of physiotherapy. *Physiotherapy* **75,** 2, 114-120

Prior L, Lai Chun P and Beng Huat S (2000) Beliefs and accounts of illness. Views from two Cantonese speaking communities in England. *Sociology of Health and Illness* **22,** 6, 815-839

Purtilo R (1990) *Health Professional and Patient Interaction.* (fourth edition) WB Saunders Company, Philadelphia

Radley A (1994) The healing relationship: doctors, patients and nurses. In *Making Sense of Illness: A Social Psychology of Health and Disease* Sage Publications, London

Ramos MC (1992) The nurse-patient relationship: theme and variations. *Journal of Advanced Nursing* **17,** 496-506

Read C (1925) *Man and his Superstitions.* Cambridge University Press, London

Rogers CR (1964) The characteristics of a helping relationship. In Bennis WG, Schein EH, Berlew DE and Steele FI (Eds) *Interpersonal Dynamics: Essays and Readings on Human Interaction.* The Dorsey Press, Homewood, Illinois

Royal Commission on Long Term Care (1999) *With Respect to Old Age: long term care – rights and responsibilities.* Stationery Office, London.

Schaffer RT and Lamm RP (1992) *Sociology.* McGraw Hill Inc, New York

Schwandt TA (2000) Three epistemological stances for qualitative inquiry in Denzin NK and Lincoln YS (eds) *The Handbook of Qualitative Research, second edition* Sage Publications, Thousand Oaks, Ca

Silverman D (2000) *Doing Qualitative Research: A Practical Handbook.* Sage Publications, London

Sim J (1986) Truthfulness in the therapeutic relationship. *Physiotherapy Practice* **2,** 121-127

Sim J (1990) The concept of health. *Physiotherapy* **76,** 7, 423-428

Sim J (1997) *Ethical Decision Making in Therapy Practice* Butterworth Heinemann, Oxford

Sim J and Sharp K (1998) A critical appraisal of the role of triangulation in nursing research. *International Journal of Nursing Studies* **35**, 23-31

Skalnik P (1999) Authority versus power in Cheater A (ed) *The Anthropology of Power: Empowerment and Disempowerment in Changing Structures*. Routledge, London

Smith JA (1995) Semi-structured interviewing and qualitative analysis in Smith JA, Harré R and von Langehove L (eds) *Rethinking Methods in Psychology*, Part 1, chapter 2, Sage Publications, London

Stenmar L, Nordholm L (1994) Swedish physical therapists' beliefs on what makes therapy work. *Physical Therapy* **74,** 11, 1034-1039

Stephenson S, Wiles R (2000) Advantages and disadvantages of the home setting for therapy: Views of patients and therapists. *British Journal of Occupational Therapy* **63,** 2, 59-64

Stern PN (1994) Eroding Grounded Theory. In Morse J (Ed) *Critical issues in qualitative research methods.* 212-223 Sage Publications, Thousand Oaks, Ca

Stewart M (1984) What is a successful doctor-patient interview? A study of interactions and outcomes. *Social Science in Medicine* **19**, 2, 167-175

Strauss A and Corbin J (1998a) *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory* Sage Publications, Thousand Oaks Ca, USA
Strauss A and Corbin J (1998b) Grounded Theory Methodology: an overview. In Denzin N.K and Lincoln YS (eds) *Strategies of Qualitative Inquiry* Sage Publications, Thousand Oaks, Ca, USA

Sully P (1996) The impact of power in therapeutic relationships. *Nursing Times* **92**, 41, 40-41

Talvitie U and Reunanen M (2002) Interaction between physiotherapists and patients in stroke treatment. *Physiotherapy* **88**, 2, 77-88

Teram E, Schachter C L, Stalker C A (1999) Opening the doors to disclosure: childhood sexual abuse survivors reflect on telling physical therapists about their trauma. *Physiotherapy* **85,** 2, 88-97

Thomas C and Parry A (1996) Research on user's views about stroke services: towards an empowerment research paradigm or more of the same? *Physiotherapy* **86,** 1, 6-12

Thornquist E (1994) Profession and life – separate worlds *Social Science and Medicine* **39,** 5, 701-713

Tinker A (2002) The social implications of an ageing population. *Mechanisms of Ageing and Development* **123,** 7, 729-735

Tonks A (1999) Medicine must change to serve and ageing society. *British Medical Journal* 319, (4 December) 1450-1451

Townsend P, Davidson N and Whitehead M (1988) *Inequalities in Health.* Penguin Books, London

Tracy MA (1938) *Nursing: an art and a science* CV Mosby, Louis

Turner BS (1986) *Equality.* Ellis Horwood Limited, Chichester

Turner R (1985) Unanswered questions in the convergence between structuralist and interactionist role theories. In Helle HJ and Eisenstadt (eds) *Microsociological Theory: Perspectives on Sociological Theory vol 2.* Sage Publications, Beverley Hills, CA

Tyni-Lenné R (1991) Towards a physical therapy paradigm. *Proceedings of the 11th International Congress of the World Confederation of Physical Therapy*, World Congress of Physical Therapy, London 238-240

University of Glasgow (1968) *Partnership in Medical Care*: *The Ninth Maurice Bloch Lecture by The Rt. Hon. Kenneth Robinson, MP Minister of Health.* Jackson, Son and Company, Glasgow

Van Rooijen AJ (1993) The implications of the behaviour of patients in the illness-role on the psychosocial relationship of physiotherapists with their patients. *South African Journal of Physiotherapy* **49,** 3, 43-44

Vernon RF (2000) *Conceptualising the therapeutic relationship: the importance of developing an adequate ontology and epistemology of personal relationships.* (abstract SPR Conference 2000) http://ted.educ.sfu.ca/Society/chicago/program/abs311.html (16/11/2000)

Vincent JA (1995) *Inequality and Old Age*. UCL Press, London

Vincent JA (2000) Age and Old Age. In Payne G (ed) *Social Divisions.* MacMillan Press, Basingstoke and London

Von Koch L, Wottrich AW and Holmqvist LW (1998) Rehabilitation in home versus hospital: the importance of context. *Disability and Rehabilitation* **20,** 10, 367-372

Wagstaff GF (1982) A small dose of commonsense – communication, persuasion and physiotherapy. *Physiotherapy* **68,** 10, 327-329

Waitzkin H (1991) *The Politics of Medical Encounters*. Yale University Press, New Haven and London

Waterworth S and Luker K (1990) Reluctant collaborators: do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing* **15,** 971-976

Watson R (2001) European countries face similar problems of demographic ageing and higher patient expectations. *British Medical Journal* **323,** (15 December) 1388

Weber M (1947) in Parsons T (ed) *The Theory of Social and Economic Organisation.* Free Press, New York

Wengraf T (2001) *Qualitative Research Interviewing* Sage Publications, London

Wiles R, Ashburn A, Payne S and Murphy C (2002) Patients' expectations of recovery following stroke: a qualitative study. *Disability and Rehabilitation* **24**, 6, 841-850

Wiles R, Ashburn A, Payne S and Murphy C (2004) Discharge from physiotherapy following stroke: The management of disappointment. *Social Science and Medicine, in press*

Wiles R, Postle K, Steiner A, Walsh B (2001) Nurse-led intermediate care: an opportunity to develop enhanced roles for nurses. *Journal of Advanced Nursing* **34,** 6, 813-821

Wilkin D, Gillam S, Smith K (2001) Tackling organisational change in the NHS. *British Medical Journal* **322,** (16 June) 1464-1467

Wilkinson G (1999) *Theories of Power in Power and Nursing Practice*. Wilkinson G and Miers M (eds) pub: Macmillan, Basingstoke

Williams D (1997) *Communication Skills in Practice: A Practical Guide for Health Professionals.* Jessica Kingsley Publishers, London

Williams J (1986) Physiotherapy is handling. *Physiotherapy* **72,** 2, 66

Williams S, Annandale E, Tritter J (1998) The sociology of health and illness at the turn of the century: Back to the future? *Sociological Research Online* **3,** 4 http://www.socresonline.org.uk/socresonline/3/4/1.html

Williams S and Harrison K (1999) Physiotherapeutic interactions: a review of the power dynamic. *Physical Therapy Review* **4,** 37-50

World Confederation of Physical Therapy (2003) *Description of physical therapy – what is physical therapy?* http://www.wcpt.org/policies/description/whatis.html (30/6/2003)

World Health Organization (1958) *The First Ten Years of the World Health Organisation.* World Health Organisation, Geneva

Wright P (1982) Men's friendships, women's friendships and the alleged inferiority of the latter *Sex Roles* 8: 1-20

Yerxa E (1983) Audacious values: the energy source for occupational therapy practice. In Kielhofner G (ed) *Health through Occupation: theory and practice in occupational therapy* 149-162 FA Davis, Philadelphia

Young J, Robinson J and Dickinson E (1998) Rehabilitation for older people. *British Medical Journal* **316,** (11 April) 1108-1109

Young J and Philp I (2000) Future directions for geriatric medicine. *British Medical Journal* **320,** (15 January) 133-134

Appendices

Appendices

Chapter 2

Therapeutic Relationships: Exploring the Literature

2.1 Journals searched for the review

Appendix 2.1

Hard copy and electronic journals hand searched for the initial literature review:

Journal of Social and Personal Relationships
Journal of Communication
Personal Relationships

Sociology
Sociology of Health and Illness
Social Science and Medicine
Social Science Research
The Sociological Review
American Journal of Sociology
Theory and Society

Age and Aging
Journal of Aging Studies
The Gerontologist
Geriatrics
Geriatrics and Gerontology International

British Journal Of Occupational Therapy
British Medical Journal
Journal of Advanced Nursing
Physiotherapy

Journals searched regularly through Zetoc:

Advances in Medical Sociology
Ageing and Society
American Anthropologist
American Journal of Sociology
American Sociological Review
American Sociologist
Anthropology and Medicine
Applied Social Research Methods Series
Archives of Gerontology and Geriatrics
British Journal of Sociology
Contemporary Sociology
Elderly Client Advisor
Gerontologist
Gerontology and Geriatrics Education
Journal of Aging Studies
Journals of Gerontology Series A
Journals of Gerontology Series B
Journal of Religious Gerontology
Journal of Women and Aging
Philosophy of the Social Sciences
Qualitative Sociology
Social Identities
Sociological Methodology
Sociological Methods and Research
Sociological Theory
Sociology of Health and Illness
Sociology Review

Appendices

Chapter 3

Exploring the Therapeutic Relationship: methodological considerations

3.1 Field notes example

3.2 An example of data analysis using grounded theory

3.3 Audit of data analysis

3.4 Data Analysis Process: The Early Development of a Sub Category

Appendix 3.1

An example of field note data

Observation study, Case 2

Literal **Treatment session**	**Interpretive**	**Reflexive**
PT crouches at the pt's wheelchair. Asks pt about her progress at home this week. Pt engages fully with the questioning. PT gives lots of encouragement given – well received.	PT posture ?conscious or not. This posture shows respect and attempt to reduce professional hierarchy as well as clinical approach from hemi side.	Is this body language automatic? Learned? Intuitive? A human or professional element?
Standing practice at mirror. PTA compliments pt on her "smart clothes". PTA and pt admires themselves in the mirror.	Dual use of human element – genuine compliment and encourage standing straight.	Value of the "normal" in an "abnormal" situation

Appendix 3.2
An example of data analysis using grounded theory

Data preparation
Interviews, field notes and observations were transcribed and entered into QSR NUD*IST 5 software package.

Each data set was read in its entirety several times and field notes made of its general impression in terms of meaning and feeling.

Open coding
Each transcript was then open coded and initial themes identified. One such initial theme was "communication". This arose from the following open codes identified by the physiotherapy clinicians:

- 'able to explain'
- interpersonal communication skills
- proximity
- eye contact
- 'hearing becomes believing'
- non verbal skills
- listening

Each of these codes arose from the older patient data. In addition, they identified another code:

- communication failure

Those codes in 'quotes' refer to 'in vivo' codes, that is, those codes determined initially by participants' actual words.

Identifying main themes
The open coding identified 94 open codes from the physiotherapy clinicians of which 69 were also identified from the older patients. The older patients identified another 60 open codes. These codes were grouped into initial themes, which were in turn grouped into seven main themes. Themes are also known as sub categories in grounded theory method.

For example, the initial theme 'communication' was included in the main theme 'constituents of the relationship' which was built up with other related themes thus:

Main theme 'Constituents of the relationship':

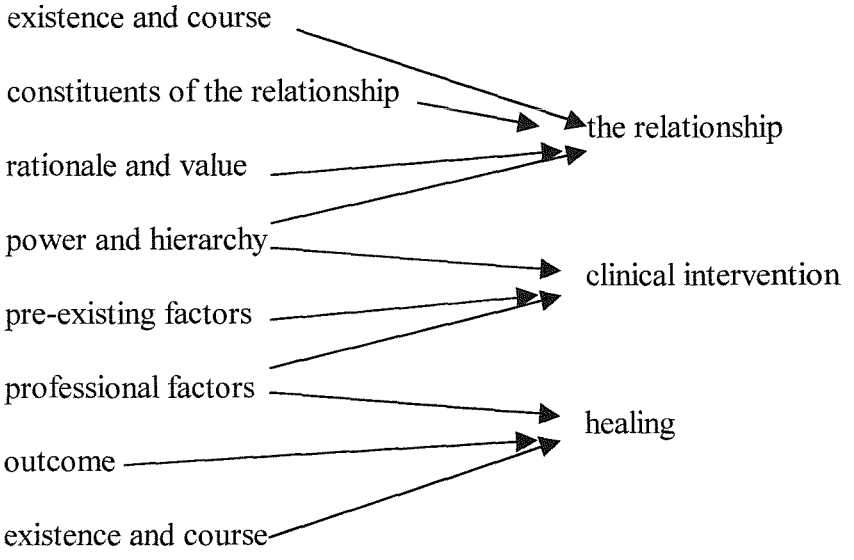
- characteristics
- communication
- touch
- continuity
- time

The seven main themes were:

- existence and course
- constituents of the relationship
- rationale and value
- power and hierarchy
- pre-existing factors
- professional factors
- outcome

Devising categories

The seven themes were then categorised into three categories that reflected the essence of the interviews. Initially these themes were called intervention, relationship and therapeutic elements (see next page 3.2.1) but were refined following analysis of the older patients' data becoming the relationship, clinical intervention and healing thus:



'Existence and course' appears twice in this list only to show the way it informs both categories 'the relationship' and 'healing'.

The categories were then defined (see chapter 4.6, page 99). To ensure category saturation the properties and dimensions of the categories and themes (sub categories) were considered. Subsequent interviews explored these until no new data arose to support or refute these categories. An example of the properties and dimensions considered within the 'communication theme' that informed 'the relationship' category is given below (3.2.2).

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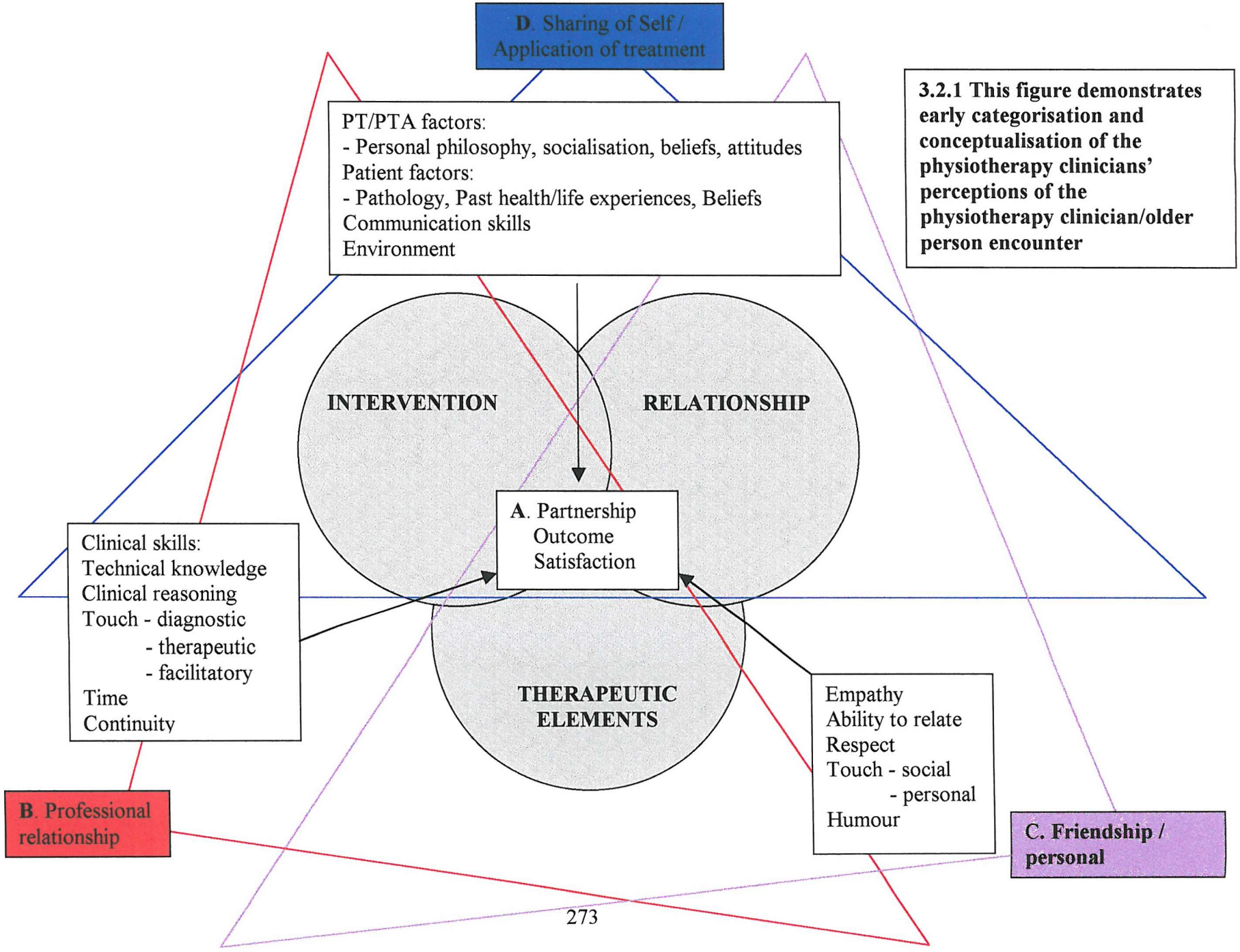

3.2.1 This figure demonstrates early categorisation and conceptualisation of the physiotherapy clinicians' perceptions of the physiotherapy clinician/older person encounter

3.2.2 Example of properties and dimensions of theme 'communication' informing category definition

Theme	Open codes	Properties	Dimensions
Communication	Verbal skills	Quality	Articulate/halting
			Directive/non directive
			Loud/quiet
		Impact	Establishes power/sharing relationship
	Non-verbal skills	Quality	Present/absent
			Pt able/unable to pick up
			PT able/unable to pick up
		Use	Conscious/unconscious
			Learned/ intuitive
		Impact	Positive/negative effect on PT/pt
	Explanation	Skill	In/ability of PT to explain
		Content	Appropriate/inappropriate
		Timing	Appropriate/inappropriate
	Confidence building	Use	Present/absent
		Importance	Very/not important
		Skill	In/ability of PT to build pt's confidence
	Relating	Range of people	Patients/family
			Managers/Peers/juniors
			MDT / cross agency
		Skill	Multi-skilled/limited
			Appropriate/inappropriate
			Learned/intuitive

Axial coding
By relating the categories to each other and the themes that made them up using the dimensions and properties to create links the data was conceptualised into three main concepts intrinsic factors, human effect and professional effect. These concepts are more abstract than the categories but remain grounded in the original data. The way these concepts fit with the three main categories is illustrated in chapter 4, fig 4.4 Model 1b.

Theoretical integration
From the first two studies exploring the experiences and perceptions of the physiotherapy clinicians and older patients it became clear that these three concepts related to the physiotherapy encounter in older person's medium to long term rehabilitation and were a useful model to continue unpicking the actual relationship that occurred within it – thus returning to the original research question, it having been impossible to separate the relationship from the encounter initially. Further literature searches were undertaken looking at keywords making up the definitions of the three main concepts. This literature together with further re-reading of the interview transcripts and axial coding of the concepts with the themes identified the final basic social concept figure 6.7 A Role Model.

This arose through considering the tensions between the two concepts 'human effect' and 'professional effect' and the influence on the relationship of such intrinsic influences as the service culture. This, related to the theme of the levels of engagement, identified the concept of 'role' that was then further explored in the observation study. The findings from this study then informed the final Role Model.

Grounding the Theory
Throughout the data analysis and interpretation care has been taken to remain true to the meaning and feeling of the original texts. This is illustrated in appendix 3.4. The origin of each theme, category and concept can be traced back to the original data. Another example of this appears in appendix 4.4.

Filling in the gaps
As the 'Role Model' emerged it became necessary to check that correct interpretations were being made. This was done by returning to the data and exploring the gaps more fully within the later case studies. Inevitably themes such as 'partnership' started to emerge more strongly than they had in the initial interviews and as time was running out and this topic was starting to move away from the initial research question it was decided not to return to earlier or new participants to explore this topic in greater depth. It has, however, informed future research questions that need to be addressed.

Appendix 3.3
Audit trail of data analysis

Study	Initial approach	Continued or amended approach
Pilot study	- Ensure there is a question to be answered - Ensure the potential participant groups are available - Test the data collection method	- Yes, go ahead - Yes, approach main study populations - Focus groups not practical, change to individual interviews
Physiotherapy clinicians' study	- Sixteen participants agreed by Ethics Committee - Initial interview guide developed - Field notes taken to inform analysis - Early findings inform later theoretical sampling - Truthfulness of data interpretation checked in PTC focus groups and presentations	- One participant declined, data considered saturated so no new participant sought - See appendix 4.3 - Reflection on interview data interpretation alongside field note data - Able to identify appropriate clinicians despite relatively small population - Early models amended to clarify terms, otherwise considered an appropriate analysis
Older patients' study	- Ethics approval for twelve participants - Interview guide informed by previous two studies - Field notes taken to inform analysis - Early findings inform later theoretical sampling - Unable to check truthfulness of data analysis and interpretation in focus groups with older patients	- Eleven participants recruited, final participant not included as impractical and unlikely to add anything new as three participants already obtained from this Trust. - Interview guide changes little (see appendix 5.1 and chapter 5.3) - Reflection on interview data interpretation alongside field note data - Problem with theoretical sampling as clinicians are gatekeepers – only note. - Findings added to final study interviews to seek older patients' views of truthfulness of analysis
Relationship in action study	- Only time for four cases, so theoretical sampling problematic - Emergent theory presented at academic and professional conferences	- Concurrent analysis of individual cases identifies concepts rather than characteristics required for final case - Theory refined and tested against existing and new data

Reflective and process memos made for each data set within QSR NUD*IST informing reflection on the appropriateness and truthfulness of the data analysis and interpretation.

Appendix 3.4
Data analysis process: The early development of a sub category

Sub categories emerged from the preliminary coding of the interview and field note data. These sub categories "pertain to the categories giving them further clarification and specification" (Strauss and Corbin, 1998). The development of the sub category "power/hierarchy" from the early physiotherapy clinicians' data is given as an example of the way in which this was done.

The topic "power/hierarchy" was not present in the initial interview schedule. The first time this notion was mooted was in the first interview when it arose through discussing the boundaries that occur in the physiotherapy clinician / older person relationship. This interview clip shows this in the context of the interviewer's questioning. I: represents the interviewer and P: the participant.

"I: Can you think of a situation where it's, where a patient has tried to engage more with you personally than professionally or where you've felt that the relationship has moved slightly too much in.. into the personal side. I'm just wondering what the boundaries are and how you identify them?

P: I don't know how I'd identify them. I can't ... at the moment think of any situation that has got out of hand because we do have the, it doesn't sound the right word but, the upper hand in that we can move away, umm, we do have control of the situation."
(C: 238-246)

The use of the words "upper hand" and "control" was picked up and explored further. It was noted that the physiotherapy clinician appeared uncomfortable with the thought of "having the upper hand".

The above clip shows how the interviewer prompted the interviewee. Although this could be construed as coercive, this participant disagreed with other statements made by the interviewer in other parts of the interview. These responses are therefore taken as reflecting the actual views of this participant. The interviewer went on to clarify what the participant had said.

"I: Do think it's the physio's responsibility to take that? [The upper hand]

P: Yes

I: Take that responsibility in that situation?

P: Yes, yes I do.

I: So there is a bit of a power balance

P: Yes

I: With the physio and the patient? With the physio having the upper hand?

P: Yes

I: Even in a working relationship that's a partnership?

P: Yes I think so, yes. I think if you didn't, umm, then you'd be heading for... could be, heading for difficulties.

I: So perhaps that's the very fact that you have that power balance there enables you to maintain the professional relationship.

P: Yes"
(C1: 247-260)

The topic of partnership was explored in subsequent interviews but the topic of power and hierarchy was not specifically raised to avoid interviewer bias and ensure that only those factors immediately relevant to the participants were identified.

However, in later interviews the topic of power and hierarchy related to the clinician/patient partnership was prompted by the interviewer to discover if, on closer inquiry, other participants did have views or experience of this.

"I: Right, yes. And for those people who trust you instantly, are they people who would trust anybody instantly or is it something to do with your approach and your personality do you think?

P: (pause)

I: Or even your professional status?

P: Yeah, I think there's elements of all of that. Umm, I think some patients respond to the professional, the persona that goes with being a physiotherapist and the image that people have of our profession."
(P1: 64-71)

This was interpreted as participants' perception of a professional hierarchy that could impact on the relationship. Once the participant had identified this, the topic was raised again in a more direct question about partnership.

"I: So the relationship is quite important to the establishment of the partnership.

P: Yes.

I: And do you think it's changing now, the power dynamics within the patient therapist partnership? Is it moving more towards the patient?

P: That's the theory isn't it. (laughs) To be honest within the elderly patients I would say no. I still think they see you as the health professional, they still see the doctors as knowing everything and being unquestioning."
(P2: 184-190)

Other comments from participants identified further examples of hierarchy.

"P: Umm... I wouldn't like to think that people, patients felt that I was the schoolmistress. I do wonder sometimes whether there's an element of that."
(P7: 150-152)

"P: ...they will still relate to the physiotherapist as the person who's in overall control."
(P3: 170)

The inherent hierarchy in the professional relationship was debated as a product or precursor of power.

"P: You know... I think also it's kind of a very uneven start point to start a friendship. They're dependent on your... not dependent, but you know, you're giving them input.

I: So there are power issues really?

P: Yeah, I think so. Umm, yeah."
(P:378-381)

"I: So in that respect do you think there are issues of, sort of, power in the relationship that are different with a physiotherapist and a patient to a physiotherapy assistant and a patient where the physiotherapy assistant may not have as much of this control?

P: I hope not, because I would hope that if I'm seeing a patient, the patient doesn't feel that I have control over the situation."
(P3: 279-283)

Participants appeared to be uncomfortable with the use of the word "power" so the word "empowerment" was used to explore the topic in a less hostile way. Empowerment is a term familiar to physiotherapists who use it to denote the gold standard of promoting the sharing of responsibilities between patient and clinician within the encounter.

"I: So do you think that moving into the more, sort of, personal elements of a patient's life and what interests them actually umm, empowers them to have, to come more into partnership with you and with the physiotherapy?

P: Yeah, I mean, I err, from their point of view I would probably say that it probably doesn't empower them at all, it just perhaps gives them, I mean empowerment is the wrong word, but it just gives them, perhaps gives them something that they can take ownership of, you know, something they know about. It's something I don't know about they can impart information to me about you know, their home life, you know, perhaps..." (P8:152-162)

Within qsr NUD*IST a tree node "Power" was created from a free node "Power in the PT/pt relationship". Subsequently another free node "Inherent hierarchy" was created.

Once the theme of "power/hierarchy" had been identified from the data, its properties and dimensions were considered in order to see if further conceptualising could broaden the sub category.

Power: Properties:	Strength
	Authority
	Knowledge
	Responsibility
	Control
	(Energy)
Dimensions:	aggressive - assumed
	taken by force – implicit
	obvious - hidden
	used - abused
	earned – inherited
	expert – novice
	extent of boundaries set by society, the organisation and/or the environment

The data was re-examined using these properties and dimensions to explore other themes that may contain elements relating to power or hierarchy. Several other examples were found. For example, the role of the physiotherapy assistant was found to exhibit power through colluding with their senior colleagues in passing on information given to them by patients. Similarly the specialist clinical skill of physiotherapeutic touch was seen to be a potential reinforcer of professional hierarchy. This professional hierarchy must also be strengthened through the physiotherapy clinician's prior knowledge of the patient before the encounter begins. However, an example was identified of how patients might turn the tables and use lack of compliance to withdraw from treatment and this was interpreted as a means of the patient asserting power within the encounter.

Because of its considerable impact within the findings, this sub category was given its own identity. Because power and hierarchy were defined slightly differently but were identified equally, the sub category was given both names. It was seen to be inherent in both the relationship and the clinical intervention and thus was influential in informing these two main categories.

Throughout the data, power and hierarchy were considered to be intrinsic to the situation and thus became included into the Intrinsic Influence concept. Participants denied that they used power in a personal way such that the sub category would fall into the Human Effect concept. Although participants accepted that professional hierarchy was inevitable, this sub category was not considered part of the Professional Effect concept as the hierarchy was, in this participant group, more related to the clinical intervention than healing categories.

Appendices

Chapter 4

The Therapeutic Relationship: The Physiotherapy Clinicians' Perspective

4.1 Physiotherapy Clinicians' Participant Information letter

4.2 Initial Interview Guide for the Physiotherapy Clinicians' Perspectives Study

4.3 Physiotherapy Clinicians' Study: Interview Schedule Development

Appendix 4.1
Physiotherapy Clinicians' Study participant information letter

University Letterhead

Ref: Study 2Ports/PT2/participant code

Date

Dear Colleague

Research Project: Optimising therapeutic relationships in elder rehabilitation: an examination of the factors affecting the formation and development of relationships between patient and physiotherapist

You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with colleagues or your line manager if you wish. 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. Thank you for reading this.

My name is Sue Barnard. I am a postgraduate student at the School of Health Professions and Rehabilitation Sciences at the University of Southampton. I have recently started my PhD studies exploring the relationship that develops between physiotherapists/physiotherapy assistants and their elderly patients. This research is being funded by a NHS Executive SE Region studentship. It is hoped that the findings will inform future undergraduate and post registration physiotherapy training.

This is an in-depth qualitative research project comprising four studies each of which will be analysed using a grounded theory approach.

1. The first study comprises focus groups with physiotherapists and elderly people to obtain a general overview and inform both topic areas and approach for subsequent parts of the research.
2. The second study explores the general views and attitudes of physiotherapists and physiotherapy assistants to elderly patients and therapeutic relationships.
3. The third study explores the perceptions of elderly people who have recently undergone a course of physiotherapy treatment to explore their experiences of health care in general and physiotherapy in particular. It will also explore participants' views on any relationship formed with their physiotherapist. Participants will be asked to compare their views and experiences of this recent physiotherapy encounter with previous health experiences.
4. The fourth study is a longitudinal study following the patient and physiotherapist over an episode of outpatient or domiciliary physiotherapy care. Physiotherapists (and, where appropriate, physiotherapy assistants) and patients will be interviewed at the start, middle and end of the episode of care.

I would like to ask you to participate in study 2. This will take the form of a single semi-structured interview undertaken in a quiet area in the physiotherapy department at a time to suit you and lasting up to one hour. During this time I will ask you to explore the topic of therapeutic relationships in elderly rehabilitation including:

- Whether you think a relationship develops between physiotherapists/assistants and their patients
- Whether that relationship is valuable
- What the relationship comprises
- Whether any problems arise within the relationship, why and how they are addressed
- What makes a relationship good/bad?
- Whether personal views towards elderly people and their rehabilitation impact on the relationship that develops
- Whether someone's experience of health care in the past (either PT/PTA or patient) impacts on their expectation of health care in the current health service.
- Whether someone's experience of health care in the past (either PT/PTA or patient) impacts on the relationship with the healthcare professional.

I would like to tape-record the interview that will later be transcribed and analysed. The findings of the study will become part of my thesis and will be offered for publication to Physiotherapy and other medical journals as appropriate. All information will be anonymised and you will not be identified at any stage.

This study has been approved by the Portsmouth Local Ethics Research Committee (ref no:.....) and is undertaken with the full knowledge and consent of Mrs Suzanne Hogg, Physiotherapy Manager and the consultants and managers at the Day Hospitals and Elderly Medicine services in Portsmouth.

If you require more information about this research please contact me at the University of Southampton (023 80 592887). My supervisors are Dr Rose Wiles is also based at the School of Health Professions, University of Southampton (023 8059 5422) and Professor Peter Coleman, Department of Geriatric Medicine, University of Southampton (023 8077 6131).

If you require more information about taking part in medical research Consumers for Ethics in Research (CERES) publish a leaflet entitled "Medical Research and You". This leaflet gives more information about medical research and looks at some of the questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London N16 0BW.

I would be very grateful if you would consent to participate. An informed consent form is attached and I will ask you sign this prior to taking part in the interview. There is no obligation to take part and you may withdraw at any time without giving a reason.

I will contact you by telephone in the next couple of weeks to see if you have any further questions about this letter and whether you would be happy to take part in this research. You may, of course, get in touch with me earlier by phone or at the address above. A full

copy of the research protocol is available on request from Suzanne Hogg, Wendy Mills or myself.

Yours sincerely
Sue Barnard MSc MCSP SRP
Postgraduate research fellow

Appendix 4.2
Initial Interview Guide for the Physiotherapy Clinicians' Perspectives Study

1. The existence and components of a relationship

- Do you consider that a relationship develops between physiotherapists/assistants and their patients?
- What does that relationship comprise?
- Is it important?
- Does a relationship always develop?
- What is the impact if a relationship doesn't develop?

** if the interviewee has problems with this question, see over*

2. The value and management of the relationship

- Is that relationship valuable?
- If so, why?
- What is its impact?
- What does the patient get out of the relationship?
- What does the physiotherapist get out of the relationship?
- What makes a relationship good/bad?
- Do any problems arise within the relationship?
- Why?
- How are they addressed?

3. Different relationships

- Is the relationship between a PTA and a patient different to the relationship between a qualified physiotherapist and the patient?
- Is the PTA/PT/patient relationship different to that developing between other health care professionals and the patient (nurse/doctor etc)?

4. Old age: Attitudes and values

- Exploration of personal views towards elderly people and their rehabilitation
- Does someone's attitudes/values impact on any relationship that develops

5. Impact of personal illness experience on any therapeutic relationship

- Does someone's experience of health care in the past (either PT/PTA or patient) impacts on their expectation of health care in the current health service?
- Does someone's experience of health care in the past (either PT/PTA or patient) impacts on the relationship with the healthcare professional?

6. Any other thoughts on the non clinical, inter-personal elements of physiotherapy that my impact on the patient's engagement with physiotherapy

- Personality
- Beliefs
- Compliance/adherence

- Influence of external influences e.g. relatives, social or educational factors

*** Examples of past relationships** ***(use this if participants having problems with topics 1 and 2).***

- Relate an example of a patient/physiotherapist encounter? Explore e.g:
- How did it go?
- Would you say a relationship developed?
- What was important in that encounter/relationship?
- Did the relationship play a role in the patient's engagement with his/her physiotherapy including outcome?
- What was the impact (if any) of the encounter/relationship on the physiotherapist, on the patient?
- Describe any problems with initiating or closing the relationship.

Appendix 4.3

Physiotherapy clinicians' study: Interview Schedule development

Initial schedule	Development 1	Development 2	Development 3
1. The existence and components of a relationship	Is it important that PT "gets on" with the patient? Does the way in which the PT and patient "get on" influence recovery? What is it about the ability to "get on" that influences recovery?	Why have a relationship? How does it benefit the PT? The pt? Is the relationship always therapeutic? Use and impact of touch in PT/pt relationship. Perceived links between relationship and partnership/outcome	Is the relationship inherently therapeutic even in the absence of physiotherapy intervention?
2. The value and management of the relationship incl. examples of past relationships	What does the relationship comprise? What are the boundaries? Examples of good, bad and different PT/pt relationships.	Examples of how relationships were initiated and ended. Value of the relationship in the management of difficult situations.	Impact of service delivery and changes on the relationship.
3. Relationships with different health care providers	Does the PT/pt relationship differ to other health care relationships?		
4. Old age: Attitudes / values	This topic withdrawn due to time constraints and participants responses not answering research question.		
5. Impact of personal illness experience on any therapeutic relationship	Any underpinning personal philosophy that informs the relationships?		
6. Any other thoughts on the non clinical, inter-personal elements of physiotherapy that may impact on the patient's engagement with physiotherapy	Does the PT/pt relationship differ from other personal relationships? Use of gender or sexuality in the development of the PT/pt relationship	Does the PT/pt relationship differ from other service provider relationships e.g. shop assistants?	

Development 1 – schedule developments early in the study (interviews 1-3)
Development 2 – schedule developments in the middle of the study (interviews 4-7)
Development 3 – schedule developments towards the end of the study (interviews 8-15)

Appendices

Chapter 5

Older Patients' Perspectives of their Relationships with Physiotherapy Clinicians

5.1 Older Patients' Interview Guide

5.2 Purposive Sampling Criteria

Appendix 5.1
Older patients' study Older Patient's Interview Guide

This interview guide is based on the findings of the pilot and physiotherapy clinician studies and informed by literature on therapeutic relationships and interviewing patients and older people. The format is loosely based on a style mooted in Wengraf (2001).

The topics in square brackets set out the topics to be explored and the questions under each heading are examples of the style of questions and words that can be used to explore these.

Prior information from medical records:

[ensures purposive sample, demographic data]

- Name
- Address and postcode
- Age, gender
- Reason for physiotherapy

Prior information from treating physiotherapist:

[ensures purposive sample]

- Did the treating physiotherapist/PTA consider that this patient was compliant with treatment? Got on well with them?

Introductory:

[Thanks, background information]

- Thanks for participating
- Can you tell me about your recent course of physiotherapy?
    - Where?
    - Who with?
    - How often?

Transition:

[Prior knowledge, prior expectations of physiotherapy and physiotherapist]

- Did you know anything about physiotherapy before you started this course of treatment?
- Did you know the physiotherapist/PTA prior to this course of treatment?
- Please describe your physiotherapy treatment (with particular reference to touch)
- Was your treatment as you expected? If yes/no, why/why not?
- Did you feel the treatment was appropriate? Did you get what you expected from it?

[Continuity]

- Did you always see the same physiotherapist/PTA?
    - Was that important?
    - Do you think this had any effect on the way you got on with your physiotherapy treatment?
- Did you know when you were going to see the physiotherapist/PTA?

- Was that important?

Key Questions:

[getting to know, getting on with PT/PTA, perceived relevance/importance]

- How well do you think you got to know NAME (Physio)..... and NAME (PTA)
- Did you talk together about things that were not directly related to your physiotherapy treatment?
  - Did you like that? Think it was important?
- What sort of things did NAME tell you about themselves?
  - What do you think about NAME telling you this about themselves?
  - Did that information have any effect on the way you saw them?
  - Did that information have any effect on the way you approached your physiotherapy treatment?
- How well do you think they got to know you?
  - What sort of things did you talk about with the physiotherapist? (may need to prompt for topics not directly related to treatment)
  - How did you feel about sharing personal things about yourself and your life with NAME(S)?
  - Do you think that sharing that information (or not) affected the way you got on with NAME(S)?
- Overall, how do you feel you got on with NAMES?
- Is it important to get on with your Physio/PTA?
  - Why?
- Did you look forward to seeing NAMES?
  - Why?
- What were the good things about this relationship (the way you got on with NAMES)?
- If you could have changed anything about the way you got on with your physiotherapists/PTA (or NAMES depending on how personal I feel the reply may be), what would that be?
- Was the relationship (way you got on with) different between NAME (PT) and NAME (PTA)?
  - If so, why do you think that was?
  - What was the effect of the difference? (on relationship, on outcome)
- Do you think it is important to get on with your physiotherapist/PTA?
  - Why? In what way?

[Relationship differences PT/PTA and other HCP]

- Is the way you got on with NAMES (your PT/PTA) different from the way you got on with other healthcare professionals you had contact with over the past few weeks (nurses, OTs, Drs etc as appropriate)?
  - In what way? (prompt from study 2 findings: touch, continuity, time)

[Effect on compliance, outcome]

- Do you think the way you get on with your PT/PTA affects the way you get on with your physiotherapy treatment? The improvement/recovery/outcome/that you achieve? (prompts: quicker? achieve more?)
- Why? Examples?

[Effect of environment]

- Where did you have this treatment?
- Did this place have any effect on the way you go on with NAME(s)? (Probe according to environment e.g. wards and own clothing etc, home and own environment etc)

Ending

[Closure]

- Do you think you will keep up your relationship/friendship (however participant has described this during the interview) with NAMES now that your treatment has finished?
    - How do you feel about that?
- Do you have anything else to say about the way you feel you got on with the physios, OTs, nurses (any other) over the past few weeks / whilst you were attending the Day Hospital etc (as appropriate)?

Other topics that can be developed as and when the participant leads:

- Touch: types and response
- Other clinical skills including assessment
- Partnership and goal setting
- Hierarchy/power

Appendix 5.2 Older Patient Study
Purposive Sampling Criteria n=12

Definitive inclusion criteria

- 65 years and over
- Able to give informed consent to participate in an interview lasting up to one hour i.e. no cognitive or learning impairment, no confusion or dementia, medically well enough to consent and participate, able to communicate adequately in English.
- Completed a course of physiotherapy in a Portsmouth or Chichester NHS Trust within the past two weeks. The course of physiotherapy will comprise a minimum of one physiotherapy assessment plus two treatment sessions. Treatment sessions can have been conducted by a physiotherapist or physiotherapy assistant / TI.

Preferred inclusion criteria

- Patients having completed this episode of care entirely within Elderly Medicine Services of these Trusts (i.e. not transferred from Medical wards or another Trust etc)
- Have received day hospital, community or domiciliary physiotherapy rather than inpatient, unless followed by non-inpatient physiotherapy.

In addition it is necessary to obtain a theoretical sample to ensure broad spread of patients' views and experiences.

Main criteria for sample are spread of geographical area, gender and age.

1. Geographical spread

	Number of participants required
Portsmouth Physiotherapy Units:	
- ADH, City	2
- THDH, City North, Havant	2
- LDH, Petersfield	1
- DDH, Gosport	1
- CES, Fareham	1
- CRT, City South	1
Chichester, city and rural surrounds	4
Total	12

Justification: size of population living in these areas and catchment areas of the various services.

2. Gender: Female: 8, Male: 4
Justification: Survival ratio of people in older age, reflects uptake of services within these Trusts.

3. Age: 65-74 years: 4, 75-84 years: 4, 85 years + :4

Justification: criteria for inclusion in older people's clinical services (lower age), reflects uptake of services within these Trusts.

Other criteria that may or may not be possible to include:

4. Social class: identified by postcode and last occupation of participant or male spouse.
   Professional: 3
   Managerial: 3
   Blue-collar skilled/unskilled: 3
   Not employed: 3

Justification: impact of social class unknown on this relationship. PTs perceive it not to be a problem from their perspective but cite cases where they feel patients with "upper class" attitudes may influence the relationship adversely.

5. Pathology:
   Neurological: 4
   Orthopaedic: 4
   General debility: 4

Justification: may not be relevant to views but will impact on length of physiotherapy episode of care and number of PTs and PTAs involved. Length of episode of care may or may not impact on type, extent and quality of relationship from patient perspective.

6. Length of physiotherapy episode of care:
Mix of patients having short (minimum of three PT sessions) and long episodes of care.
Justification: there may be a link between relationship development and length of relationship dictated by length of episode of care.

7. Past physiotherapy history:
Mix of patients having their first or subsequent course of physiotherapy including patients on review and those having been seen on review for several years.
Justification: past experience of physiotherapy or previous knowledge of treating physiotherapist my impact on the relationship.

8. Referral:
Mix of patients referred by GPs and consultants. To include primary referrals.
Justification: Patients in different Trusts follow different referral routes and may see the same or different physiotherapists as they move through the episode of care e.g. from inpatient to day hospital to domiciliary. It is not known whether these consistencies/inconsistencies in treating physiotherapist impact on engagement, relationship or outcome.

9. Good/bad relationships: Patient participant from at least one poor/bad relationship as defined by PT/PTA.
Justification: GTA requirement for "negative cases". As few poor/bad relationships were identified by Study 2 participants, it may not be possible to find such a patient participant consenting to be interviewed within the data collection period.

Appendices

Chapter 6

The Relationship in Action

Appendix 6.1 The Relationship in Action Observation Guide

Case number .....

Date and time.....
Venue.....

Setting and participants (incl map)	Literal	Interpretive	Reflexive
Pre- treatment and introduction			
Treatment session			
Closure			

Points to note during the observation

- How both parties act and react to requests, comments, actions and intrusive events
- Different levels of sharing information
  - professional
  - personal
  - "chitchat"
- Response of the other party to this
- Response to attempts to form or develop a relationship e.g. initiation, engagement, rejection
- Use of and response to humour
- Touch and response to touch in relation to formation/development of the relationship
- Inclusion/exclusion of either party or others
- Impact of the relationship on clinical effects and vice versa
- Power/hierarchy/manipulation

NB. This observation grid was originally produced over six pages to allow for notes to be made. All the original headings remain but the form has been condensed for inclusion in this thesis.

Appendix 6.2 Observation Study
Physiotherapy Clinicians' Interview Guide

This interview guide is based on the findings of the first two main studies and informed by literature on therapeutic relationships and interviewing patients and older people. The format is loosely based on a style mooted in Wengraf (2001).

The topics in square brackets set out the topics to be explored and the questions under each heading are examples of the style of questions and words that can be used to explore these.

Prior information:

[description of sample, demographic data]

- Name
- Grade
- Gender
- Level of experience

Introductory:

[Thanks, background information]

- Thanks for participating
- Can you tell me how long you have treated this patient during this course of physiotherapy / previous courses of physiotherapy?
    - Where?
    - Who with? (e.g. PTA, other MDT, relative etc)
    - How often?

Transition:

[Prior knowledge, prior expectations of this encounter and the patient]

- Did you know anything about this patient before you started their course of treatment?
- Did you have any preconceived ideas of what the patient would be like / how you might get on with them?
- Was this patient as you expected? If yes/no, why/why not?

[Continuity]

- Is it always you who sees this patient?
    - Is that important?
    - Do you think this has any effect on the way you get on with this patient?

Key Questions:

[getting to know, getting on with this patient, perceived relevance/importance]

- How well do you think you got to know NAME (patient)?
- Would you say that you have formed a relationship with this patient?
    - If yes, what sort?
    - If no, why?

- How did you go about forming/developing a relationship with this patient?
- Has this developed/changed since you first started treatment?
    - What initiated that development or change?
- Is this relationship good/bad?
    - What makes this relationship good/bad?
- Do you see this relationship as having a value to the physiotherapeutic encounter? If yes/no, why/why not?
- What effect do you think this relationship has? (Prompt with the following if necessary) on
    - Gaining information from the patient?
    - Gaining compliance?
    - Imparting bad news?
    - Discharging the patient?
        - And vice versa?
- How do you think the patient perceives this relationship?

[Points arising from the observation – only those relating to the relationship]

- Physiotherapy clinician approach
- Patient response
- Physiotherapy clinician response to patient comments or actions
- Role of hierarchy/power/manipulation in both parties
- Sharing of self
- Touch
- Humour
- Response to interruptions

[Relationship differences, effect of age of patient and Frame of Reference]

- Is this typical of the type of relationship you form with patients or different to usual? If so, why?
- Are there particular characteristics in the relationship you form with older patients such as NAME (pt)?
- Do you form different relationships with younger patients?
- Is there any difference in the relationships you form with rehabilitation patients and acute, short-term patients?

[Effect on compliance, outcome]

- Do you think the way you get on with this patient is affecting clinical outcome? Why?
- Is this different to other patients?

[Effect of environment]

- Did the treatment environment have any effect on the way you related to NAME (pt)? (Probe accord to environment e.g. wards and uniform etc, home and patient's own environment etc)

Ending

[Closure]

- Do you think you will keep up your relationship with this patient now that your treatment has finished?
    - Why?
    - How do you feel about that?

- Do you have any other comments regarding therapeutic relationships?

Other topics that can be developed as and when the participant leads:

- Role of clinical skills in the relationship
- Partnership and goal setting
- Hierarchy/power

Appendix 6.3
Observation study Older Patient Interview Guide

This interview guide is based on the findings of the first two main studies and informed by literature on therapeutic relationships and interviewing patients and older people. The format is loosely based on a style mooted in Wengraf (2001).

The topics in square brackets set out the topics to be explored and the questions under each heading are examples of the style of questions and words that can be used to explore these.

Prior information from medical records:

[ensures purposive sample, demographic data]

- Name
- Address and postcode
- Age, gender
- Reason for physiotherapy

Introductory:

[Thanks, background information]

- Thanks for participating, assurance of complete confidentiality
- Can you tell me about your recent course of physiotherapy?
    - Where?
    - Who with?
    - How often?

Transition:

[Prior knowledge, prior expectations of physiotherapy and physiotherapist]

- Did you know anything about physiotherapy before you started this course of treatment?
- Did you know the physiotherapist/PTA prior to this course of treatment?

[Continuity]

- Do you always see the same physiotherapist/PTA?
    - Is that important?
    - Do you think this has any effect on the way you get on with your physiotherapy treatment?

Key Questions:

[getting to know, getting on with PT/PTA, perceived relevance/importance]

- How well do you think you have got to know NAME (Physio)..... and NAME (PTA)
- Overall, how do you feel you get on with NAMES?
- Do you look forward to seeing NAMES?
    - Why?
- What are the good things about this relationship (the way you get on with NAMES)?

- If you could change anything about the way you get on with your physiotherapists/PTA (or NAMES depending on how personal I feel the reply may be), what would that be?

- [This question only where applicable] Is the relationship (way you get on with) different between NAME (PT) and NAME (PTA)?
    - If so, why do you think that is?
    - What is the effect of the difference? (on relationship, on outcome)
- Do you think it is important to get on with your physiotherapist/PTA?
    - Why? In what way?
    - Has the relationship (way you get on with) NAME(S) changed over the time you have been having physiotherapy treatment?
        - In what way?
        - What effected those changes?

[Points arising from the observation – only those relating to the relationship]

- Physiotherapy clinician approach
- Patient response
- Physiotherapy clinician response to patient comments or actions
- Role of hierarchy/power/manipulation in both parties
- Sharing of self
- Touch
- Humour
- Response to interruptions

[Relationship differences PT/PTA and other HCP]

- Is the way you get on with NAMES (your PT/PTA) different from the way you get on with other healthcare professionals you have contact with? (nurses, OTs, Drs etc as appropriate)?
    - In what way? (prompt from study 2 and 3 findings: touch, continuity, time)

[Effect on compliance, outcome]

- Do you think the way you get on with your PT/PTA affects the way you get on with your physiotherapy treatment? The improvement/recovery/outcome/that you achieve? (prompts: quicker? achieve more?)
- Why? Examples?

[Effect of environment]

- Does the place where you have your physiotherapy treatment (home or day hospital) have any effect on the way you get on with NAME(s)?

Ending

[Closure]

- Do you think you will keep up your relationship/friendship (however participant has described this during the interview) with NAMES when your treatment has finished?
    - How do you feel about that?

- Do you have anything else to say about the way you feel you get on with the physios, OTs, nurses (any other) that you are meeting whilst you are having this treatment?

Other topics that can be developed as and when the participant leads:

- Touch: types and response
- Other clinical skills including assessment
- Partnership and goal setting
- Hierarchy/power/manipulation

Appendix 6.4
The Relationship in Action. Purposive Sampling Guide

This will vary as theoretical sampling takes precedence over purposive as study progresses.

- Four cases
- One from each participating NHS Trust

- One case - physiotherapist and patient
- One case - specialist senior physiotherapist and patient
- One case - physiotherapy assistant and patient only
- One case - physiotherapist and physiotherapy assistant and patient

- One case - domiciliary venue
- Other cases - Day Hospital / outpatient environments

Physiotherapy clinician characteristics

- Willing to participate and give informed consent
- Prepared to assist in selection of appropriate patients and introduce them to the researcher
- Variety of grade and experience
- Preferably not involved in other current clinical research projects e.g. the stroke research project
- Able to make themselves available for an interview lasting up to one hour within a few days of the observation (before the next treatment session if possible).

Older patient characteristics

- Aged over 65 years
- At least one male
- Willing and able to give informed consent to participate
- Willing to have a treatment observed by the researcher
- Willing and able to be interviewed at their own home within a few days of the observed treatment session (before next treatment session of possible).
- Preferably be at different stages in their rehabilitation (early treatment to pre-discharge or review).